HOSPITAL BED AD HOC ADVISORY COMMITTEE

Conference Room A
Holiday Inn Conference Center
7501 West Saginaw Highway
Lansing, Michigan 48917

Tuesday, December 2, 2003

APPROVED TRANSCRIPT/MINUTES

Ad Hoc Members Present:
James F. Ball, Chairperson
Dale L. Steiger
Cheryl Miller
Robert Asmussen
Deborah Ebers (arrived 10:15am)
Don VeCasey
James B. Falahee
Patrick O'Donovan
Norah Maloney-Peash
John L. MacLeod
Larry Horwitz
Terry Gerald
Karen Yech
Lody Zwarensteyn
Adam Miller

Michigan Department of Community Health Members Present:
Larry Horvath
Brenda Rogers
Stan Nash

General Public Attendance:
There were approximately 29 people in attendance.

MR. BALL: I'll call the meeting to order. First order of business is to ask for any declarations of conflicts of interest. Do any of the ad hoc committee members have conflicts to declare? Seeing none, I'll move on to review of the agenda. Are there any additions, deletions, or corrections to be recommended for the agenda? Seeing none, I entertain a motion to approve the agenda.

MR. ZWARENSTEYN: So move.

MR. VeCASEY: Seconded.

MR. BALL: Moved by Zwarensteyn. Seconded by VeCasey. All those in favor say aye. (Vote taken)

MR. BALL: Opposed. (None voiced)

MR. BALL: That's the agenda. I believe all members received minutes from the prior meeting. I assume that you've reviewed them. Are there any additions, deletions, or corrections to be recommended for the minutes? Seeing none, I would entertain a motion to adopt the minutes.

MR. FALAHEE: Move to approve.

MR. ASMUSSEN: Support.

MR. BALL: Falahee moved. Asmussen supports. All in favor say aye. (Vote taken)

MR. BALL: Opposed? (None voiced)

MR. BALL: The minutes are approved. Why don' t we start with Don and go around and identify ourselves.

MR. VeCASEY: Don VeCasey representing the AARP.

MR. ASMUSSEN: Bob Asmussen, St. John Health System.

MR. FALAHEE: James Falahee, Bronson Healthcare Group.

MR. O' DONOVAN: Patrick O' Donovan, William Beaumont Hospital.

MS. MALONEY-PESH: Norah Maloney-Pesh, Mount Clemens General Hospital.

MR. MacLEOD: John MacLeod, Munson Healthcare.

MR. HORWITZ: Larry Horwitz, Economic Alliance.

MR. GERALD: Terry Gerald, Detroit Medical Center.

MS. YECH: Karen Yech, Lakeland Regional Health System.

MS. MILLER: Cheryl Miller, Trinity Health.

MR. BALL: Jim Ball, General Motors representing MMA.

MR. STEIGER: Dale Steiger, Blue Cross.

MR. ZWARENSTEYN: Lody Zwarensteyn, Alliance for Health.

MR. MILLER: Adam Miller, the UAW, representing the AFL/CIO.

MR. NASH: Stanley Nash from the Certificate of Need program.

MS. ROGERS: Brenda Rogers, Certificate of Need.

MR. HORVATH: Larry Horvath, Certificate of Need.

MR. BALL: Okay. I guess we should move directly to the report from Dale concerning the updated activities of the TAC, and, in particular, at the last meeting we received a letter from Sparrow Hospital raising several issues and I believe the TAC in its deliberations has addressed those. So, if you could address those in your report, I'd appreciate it.

MR. STEIGER: Okay. I think we' ve passed copies of a draft letter out. The letter is written to Jim. It is signed on behalf of all the TAC committee and we are going to add some clarifying language to this letter between now and the commission meeting. But there were several issues that were dealt with in the letter that was delivered to us at the last meeting. I think this letter pretty much addresses most of them. I don' t particularly want to read the letter. Maybe we could take a few minutes and just go through the letter. If there are -- (Discussion held off the record. Technical problems dealt with)

MR. STEIGER: The first issue that was raised had to do with the revised sub-area issue being out of the scope of the authority of the TAC. I think we' ve pretty well addressed that issue in here. Certainly, the sub area revision was a major part of this project from the very beginning. There were certain hospitals at the beginning that pushed very, very strongly for sub-areas to be revised. I think some of the hospitals initially thought that sub-area revision would be the be all to end all. So, I think it' s very clear to everyone, if you look through the language there, as to why the sub-areas were looked at and reviewed.

The second issue was the issue of revising the Health Service Areas as a starting point. The Technical Advisory Committee talked about that. We decided that after our initial several runs there really was no need from a bed need or service area revision, there was no need to do that. We also felt that there was such

language in 619 that would preclude the advisory committee from making changes in the HSA boundaries. And so, we elected not to do that.

The Technical Advisory Committee felt that there was no standing in there to change them, there was no standing in the charge to make those changes, and the bottom line was that even making changes in the HSAs, if we could, would have no impact on the final outcome of the service area, sub-area definitions, or the bed need.

The other issue was alphas. I'm going to- I think we have a response here. We planned on adding some clarifying language to that response. If there are folks that continue to have questions, I would take the question. I would rely on Stan to give us some background information if there are additional questions. I think Stan gave a very, very lucid and valid response to those questions at the last meeting. I am not sure that the language is in the minutes quite frankly. I was stuck up north yesterday and I have not seen them at this point. If there are additional questions, we could take those at some point. And the same response would be for the iteration issue.

(Deborah Ebers arrived 10:15am)

MR. STEIGER: The last statement had to do with no formal minutes in the TAC process. I think one of the original charges that was given to us by the Commission indicated that we would be functioning as an informal group, that no minutes were required, and, therefore, no minutes were taken. I would also point out that for every TAC meeting on each issue there was very, very thorough discussion and every recommendation that came out of the TAC was based on acclimation. There really were -- after discussion there were no dissenting views that were voiced. If there were, we would have continued the discussion until we made changes in the recommendation or people were satisfied with the answers that were given. But I can state unequivocably that there really were no dissenting voices when recommendations were finally agreed on. Jim, I throw it back to you.

MR. BALL: What would be the recommendation then from the TAC for adopting these recommendations and moving them forward to the Commission?

MR. STEIGER: When we left last time there were really three issues on the table. One was revision of the sub-areas. The second -- which we discussed in great detail
last time. The second issue was the bed need numbers themselves, which we were waiting on the department to furnish. And the third issue was the new criteria for comparative review standards. I think we've discussed in detail the sub-area revisions. Obviously, there will be additional discussion on that area today I'm sure But at
this point I would like to throw the discussion over to Larry Horvath who can walk us through the bed need numbers, which I believe in summary have been distributed. But I'll let Larry do that and we'll come back to the comparative review issue.

MR. HORVATH: Larry Horvath from the Department of Community Health. Pretty much each member should have a summary packet that actually has all of the sub-areas statewide. In addition, this morning we handed out a statewide sheet that gives you the total for the state.

There is still work to be done on this with some technical changes for the department as it checks its inventory. Pretty much what you will look at is each of the sub-areas, and the sub-areas we actually compared this with the most current licensing file from the Department of Consumer and Industry Services. So, we did verify with them on the licensing count, the facility number, and the name of the facility to update these tables.

So, what you have is individual sub-areas with the most current department inventory and the most current licensing inventory. And then you have some footnotes on each of these pages as applicable. Some would reference the TAC decision rule that is being proposed, which would exclude critical access hospitals from sub-areas that have noncritical access hospitals in the bed supply. We can talk about that a little bit later. And then there are some other footnotes that there might be some discrepancy between the licensing count and the department's count, which the department reserves the right to correct that at a later date as we investigate that further.

There was approximately seven less sub-areas from the last hospital sub-area divisions. The bed need, the current bed need is at 17,311. When Stan reran the numbers based upon the decision rule and the

methodology from the TAC committee, the new proposed bed need number would be 19,836 as you see on the statewide table, which leaves an excess of 7,800 beds in the state.

A couple of things on the statewide table that, you know, you will see on the statewide table there are several columns. The sub-areas are numerically and alphabetically labeled now. That provides a distinction from the old sub-area so we don't confuse them. You have the licensing column, which is what is actually licensed in the State of Michigan by the Department of Consumer and Industry Services. You will have the department bed inventory, that is the inventory count of what has received CON approval. So, for instance, you could have a higher number in the department inventory because somebody just got approved for 20 additional beds to build a wing and they have yet to build that wing; therefore, it's not reflected in the licensing count. Or the other thing that could happen is that somebody has a licensed bed with licensing and it just has not been reflected in the department's column as of this date. Then you will have the statewide bed need number for each sub-area. Then you'll have the bed need or bed excess in the last column for each of the areas.

MR. STEIGER: I assume the audience has been given a copy of this?

MR. HORVATH: That has been put on the back table. If we want to go to one example, we can point that out for people.

MR. STEIGER: Let's do that.

MR. HORVATH: If we want to take a look at 7-F in the tables. Kalkaska, Leelanau, and Paul Oliver, all three have been designated federally as a Critical Access Hospital. Their days of care was actually calculated in the bed need formula, but their actual bed supply was not counted in the actual supply column. That was the decision rule from the TAC. So, what you see is that in the department inventory even though we have 8 beds for Kalkaska, 23 for Leelanau, and Paul Oliver has 8, we do not -- we do not total those because they're Critical Access Hospitals and, therefore, the bed sub-area total would be 354 and the bed need would be 349. And so, there's still in excess of 5 beds there even with that proposed decision.

MR. BALL: I have a couple of public comment cards for people who wanted to address the sub-area changes and I guess at this point it would be appropriate to hear from them.

MR. STEIGER: Well, I guess, why don't I just run through the comparative review issue then we'll basically have everything on the table in one fashion or another.

The last several meetings we've talked about the need to develop comparative review criteria that would be used in those instances where there was a need in a particular sub-area and more than one applicant. We discovered several months ago that there are no comparative review criteria within the bed need standards and we felt at one point that in order to develop a complete product for the Commission, that we needed to not only address the sub-area issue and the bed need issue, but take a look at and reveal comparative review criteria for hospital bed need.

The Technical Advisory Committee met several times on this issue. We actually had developed seven very broad categories within which we wanted to develop more specific criteria. For example, one of the categories was the facility's participation in Medicaid program. We felt that that was a very, very important issue that needed to be dealt with by all of the applicant hospitals, for, again, when we had situations where there was a need.

As I said, the TAC met several times, had spent quite a few hours discussing this issue, and at the last meeting two weeks ago we finally concluded that we weren't going to make sufficient progress on this issue such that we could make a report back to the bed committee and subsequently CON Commission. We felt because we were not making sufficient progress, that we needed to recommend to the Bed Need Ad Hoc Committee that this issue be addressed in the future, but that it be addressed by a group other than the Technical Advisory Committee. I won't say that we're all technicians on that committee, but we felt that others might have a broader perspective in terms of some of the criteria, public policy criteria that should be baked into these comparative review criteria. The TAC has recommended that this be done. We're hoping that the Bed Need Ad Hoc Committee would concur in that recommendation, but we are not at this point going to recommend specific criteria that should be forwarded on to the CON Commission. If there are other TAC members that care to add anything to that, please feel free.

MR. BALL: Larry Horwitz.

MR. HORWITZ: Larry Horwitz. Do we have somewhere that we can cite for people what you just said about the comparative review criteria in writing? Is that part of this report that's on the tab called technical workgroup report?

MR. STEIGER: It is not at that point. Hopefully we'll be able to develop something, some summary of that, that will go on to the CON Commission, but at this point we don't.

MR. HORWITZ: I think that would be helpful so they have that guidance to have it --

MS. JACKSON: It is on Page 30 of this report.

MR. BALL: I was going to say I believe we had them at the last meeting.

MR. STEIGER: Did we deal with it? I spent yesterday fixing my furnace up north.

MS. JACKSON: This report that we generated that was distributed, right on Page 30 gives the categories for the --

MR. STEIGER: Categories, yes. But what we need, I think what Larry was referring to was a recommendation that someone else look at it and try to develop it along the same categories, but we're not going any farther.

MR. HORWITZ: Just I presume that the department staff will have to be sending out materials to the commissioners in the next day or two. You think we could make sure they have that material that Barbara Jackson just raised?

MR. STEIGER: We actually do have a document if we can work this into the department submission, we do have a document that the person on the TAC put together that talks about the seven categories and actually summarizes what we had done up to this point. But again, we're not talking a specific recommendation in terms of these categories, but I think this document would certainly be blended in.

MR. STEIGER: Cheryl.

MS. MILLER: Cheryl Miller. I think that's probably part of our homework assignment today before we leave is to determine what materials and in what form we're going to send all of this out of the ad hoc to the CON Commission, both the Power Point document we discussed at the last ad hoc, as well as all of the bed inventory and bed need numbers, the comparative review. All of this -- I think before we leave today we need to decide in what format. Obviously, we only have a day or two turnaround. I think the point is well taken, we probably need a discussion of that by the end of the day.

MR. HORWITZ: Larry Horwitz. I would recommend that the ad hoc agree, we move at the appropriate time, Mr. Chairperson, that material that was written up by the TAC group that explained what we did and how we did it, plus this recommendation that the comparative review issue be dealt with, with those -- I think we had six or seven criteria that we thought should be there. So, it's not that we're not recommending something. We're saying these are the criteria.

MR. STEIGER: We're recommending it be dealt with by the others, these categories be looked at, yes.

MR. HORWITZ: List what these categories are, but the issue we're not dealing with, that TAC didn't deal with was exactly how many points get assigned to each criteria and how to measure the eligibility for those points.

MR. BALL: Jim Ball. I think it really -- if I understand, let me tell you what I think I'm hearing from the TAC, that is that there was an issue at the last Commission meeting that went to if hospitals were to be approved, and if standards were to be approved, there were some of these socioeconomic and other issues that would be addressed. And we came back to the ad hoc and we said, was this part of our mission? And there was some feeling that since it had been raised, I think by Mr. Christensen of the department, in the meeting, that we ought to incorporate that in whatever our thinking was. But now I'm hearing that it's really a separate need or a separate issue from bed need. Bed need is sort of an objective kind of thing, where comparative review is

more subjective. And while the ad hoc, or the TAC says that this ought to be looked at and comparative review standards ought to be developed, that's not what we have done and what we're moving forward to the Commission.

MR. STEIGER: Right.

MR. BALL: What we're doing is suggesting to the Commission that they ought to look at that, and in doing it, should take into account things like the seven items identified.

I think we also received a letter from the Alliance for Health over in Grand Rapids with some suggestions on issues that might be considered for comparative review. And I don't know that we're suggesting to the Commission that they should limit themselves to those seven topics, but that they should look at the issue and among the things they look at would be those seven topics.

MR. HORWITZ: That's certainly my understanding.

MS. MILLER: Cheryl Miller. Just a little bit more detail. The reason I think we spent -- as Dale said, we spent a lot of time looking at these criteria and discussing them, and there was fair amount of consensus on the categories.

Where we ran into trouble is that we didn't feel as though we had the expertise in the financial area, and as we started looking at some of the criteria that were financially focused as opposed to bed need, which is what we were -- how we were comprised, how we were put on this group, we felt as though we just didn't have the technical expertise in the financial arena. That's why we decided not to meddle where we didn't feel as though we had the ability to provide guidance.

MR. GERALD: Terry Gerald of the Detroit Medical Center. I have a question and a comment. My question is, I want to be assured that recommending to the Commission new items is in the charge of the Ad Hoc Advisory Committee, first of all.

And secondly, in terms of a comment, if the TAC itself is not competent that they've had sufficient broad-based policy input in terms of what criteria should or should not be included, I personally would not be comfortable sending a list to the Commission saying these are things that should be considered. It seems to me that if we need that kind of broad policy input, that we should have that input on those specific criteria. Some may feel those criteria are appropriate, some may feel those criteria are nonappropriate. I'm not sure I would be comfortable representing to the Commission a list at this point.

MR. BALL: It may be a semantic difference, but I think there is a difference between making a recommendation to the Commission for action and making a suggestion to them. I think because of issues that were raised at the last Commission hearing, of some of these, you know, nonobjective issues if you will, it was incumbent on us to at least look at the issue of comparative review.

And so, while we're moving, hopefully moving forward to the Commission as a result of today's date a recommendation on sub-areas and bed need calculations and so forth, we're saying to them that we are not giving them a recommendation on comparative review, but we're suggesting to them that they ought to be developed and, among other things, here's some things that you might consider. Not making, you know, a formal recommendation for them to adopt or not suggesting that that is an exclusive list of issues that they would look at.

MR. GERALD: If I could, Terry Gerald again. I don't have any problem recommending or suggesting to the Commission this activity should take place, that there should be some kind of group do that, but the problem I have is once you submit a list you -- even if it's not -- you're not asking them for approval, once you put a list of anything out there you basically set the agenda and you put people on the offense and on the defense and they end up responding to that list.

If we don't feel that we had sufficient broad policy input as to what the list should even be, once you put that out there you do set the agenda, whether you ask them to approve it or not, and I would have a concern with that.

MR. HORWITZ: Mr. Chair, Larry Horwitz. At least I wasn't at the meeting to say we went this far but couldn't

go farther. My understanding was that the group felt comfortable on the list of criteria. Namely, the statute says you have to give very high emphasis on participation of Medicaid. We had a thing about indigent care. We went through and picked out, very carefully picked out criteria from the statute, where the statute has certain concerns that is expressed. Where I think we stopped, it wasn't sure whether Medicaid should count 30 percent of the points or 29 percent of the points or 45 or whatever else, and how to measure that accomplishment. But I thought, people of the TAC that were there can help me, because I wasn't, but they felt comfortable with the list of criteria as being the appropriate list and feel comfortable to come to this ad hoc group making that recommendation.

The point I'm concerned about is since the objective of the enterprise is to have updated CON hospital bed need criteria, if it then develops at some point in time someone submits an application for needed beds and we say, okay, this new sub-area needs, you know, 46 beds, but there are no criteria in the Commission document for the department to determine who wins those beds if there are more applicants than -- more people applying than the sum total, then you've reached a dead end. We have comparative review criteria as is required by statute in all of the bed standards, nursing homes, et cetera. For reasons I haven't been able to figure out, somehow we've been going for ten years since the '88 law was passed without them here.

So, I think people are comfortable with this. I think that's the reason we should have the ad hoc look at it and see if they're comfortable with these criteria, without getting into the issue whether it counts 10 percent of the points or 20 percent of the points or you measure, you know, Medicaid participation by percent of days or percent of money or whatever else.

Now, I hope someone from the TAC can help me with this. That's what I was told is where the TAC got to.

MR. BALL: Terry.

MR. GERALD: Terry Gerald again. First of all, I don't know if I got the answer to my first question. Is it within the purview of the charge of the ad hoc to recommend anything on comparative review to the Commission? If you can answer that question for me first.

MR. BALL: I don't know that, you know, we've had a pronouncement from anybody on that issue. I think personally that it's arguably within the charge that we have, especially since it was raised, you know, by the department in the last Commission meeting and was suggested that it was a shortcoming of the efforts that this committee had had in the past. And if I'm hearing -- not having sat in on all the talks, if I'm hearing the conclusion is that those issues need to be addressed by the Commission, but that it is not part of the bed need per se. What we're doing and recommending to the Commission is how to determine bed need, and if there is a need then, as Larry had said, somebody is going to need to address, well, what are the comparative review criteria. But this committee is not making a recommendation on that at this point.

MR. ZWARENSTEYN: Lody Zwarensteyn. If I can, I want to thank the group for starting a list. Unlike Mr. Gerald, I'm not uncomfortable putting this out. It would be an agenda, but that agenda when presented to the Alliance for Health did serve a very constructive end. It got the Alliance for Health committees to talk about this.

We have several additions we would like to see on that list. We would like to see the Commission informed that comparative review criteria are needed, but that the issues are a little broader than could be arrived at now. And I would like to see an illustrative list set for the Commission to show them the types of things, but not make it the know all to end all. If it is we can sit here for a long time discussing exactly which finer points of which issues should be added or not, and I can guarantee you won't see Christmas.

I think these are issues that should be taken a look at seriously by a pretty broad group. It's not an all provider group. It's got to be something very representative of the state and it's something that should not be inclusive to the point where we say this is the agenda, this is the list, and that's it, and the Technical Advisory Group has decided that's what it's going to be. But on the other hand, having an illustrative list does serve the purpose of getting people to react where you do want reaction. I'm fully supportive of moving forward without comparative review criteria now, with the notion they must be worked on and here's an illustrative group, but there are potentially others that can be added.

MR. HORWITZ: Mr. Chairman, I understood that the dialog that you had by letter, E-mail, with the chairman, chairperson of the Commission established that she was interested in having you address these issues. I had

a flurry of E-mails. I'll respond to Terry specifically.

MR. BALL: That is correct. I did have an exchange of E-mails with the chair of the Commission and she did indicate that the Commission did want us to look at that issue and not to exclude it from our deliberations. But having done that, if we go forward and say we don't have a recommendation to make on that issue, you know, I don't think she should not take our recommendations on other points.

MR. HORWITZ: I'm only trying to address Terry Gerald's specific question, is it in our jurisdiction. We're a creature of the CON Commission. Interpreting those words, the source -- or interpreting those words is the chairperson of the Commission. She's interpreted. We made a recommendation at the TAC, which was part of the materials that were given to the ad hoc at its prior meeting, not the first time we've seen them, what Barbara Jackson waved around, it has a list and so it is a recommendation that these criteria be -- basically we're recommending these criteria for comparative review criteria and the Commission can then take that under advisement. Then the question is how do you get to the point of saying, okay, we're going to give 10 percent of the points this way and we measure them so forth. That's the next step. We've gone as far as we can in compliance with the Commission's chairperson's indication to us what we're supposed to do with it. I think Terry has raised a valid question. I was trying to respond to it.

MR. BALL: Any other comments?

MR. VeCASEY: Don VeCasey. It seems to me we've got ourselves in a bit of a pickle here. The Commission has been expanded so there are a lot of new members on it, is that right? One of our roles is to try to educate them. It seems to me that we've uncovered a lot of areas that we need to look at, which we've considered to be formally outside the official charge of this committee. So, shouldn't we be preparing recommendations that deal with our formal charge and then sort of an, oh, by the way, here are other issues that have come up. Here are the minefields through which you're going to be moving. Here are some suggestions. And sort of adopt those as an appendix or addendum to the recommendation of the formal charge. Can we not do that and in this case say, for example, here are things that the TAC committee unanimously accepted as valid criteria. There may well be other issues which need to be explored in a different setting. And you can also throw in the fact that even if you arrive at the criteria, giving them relative weights is another issue. We don't have to do that itself. It seems to me that we have to let the Commission know that that is something that is going to come up.

MR. BALL: It strikes me that we're all saying the same thing and in a different way and we're spending a lot of time debating what seems to be a consensus decision that we're not going to recommend comparative review standards to the Commission, but we are going to comment to them that it needs to be done and there are several areas that they might want to explore in doing that. Now --

MR. STEIGER: That very well summarizes it, Mr. Chairman.

MR. BALL: If we have a consensus on that, we can move forward to the other issues, okay? So, let's-

MS. EBERS: I support that.

MR. BALL: And if somebody feels it's necessary to have a motion to that effect, we can do it, but I think we're all pretty much in agreement of how we want to approach that comparative review issue.

MR. HORWITZ: Presuming that Deb Ebers just made a motion, I'm glad to second it just so we can get going. I presume the significant amount of testimony we need to hear are people's concerns about subareas and bed need and so forth.

MR. BALL: Okay. There is a motion by Ebers, supported by Horwitz. Is there any discussion?

MS. ROGERS: What is the motion?

MS. EBERS: The summary that Jim so adroitly put together in terms of sending the recommendation to the Commission that there are not -- we're not going to forward a comparative review standard. We're going to identify issues that need to be explored. We would recommend that because of the breadth of the issues that a broader group take a look at these, use the list as an illustrative list, and forward those comments to the Commission.

MS. ROGERS: Thank you.

MR. BALL: Mr. Meeker, would you like to comment on this before --

MR. MEEKER: My name is Bob Meeker and I was a member of the TAC and I would just like to address the specific motion. I do think that as has been said a couple times, the TAC spent a lot of time really considering these things and we went a long way down the road. It wasn't just, well, these are good ideas, we don't know how to measure them, and we gave up. We got a long way down the road with ideas on now to measure many of them. So, I would suggest that this is not just sort of a casual list, but a list that had a lot of thought behind it. And to address Mr. Gerald's concern, I would hate to see all that discussion just sort of cast away and say, well, we think there ought to be comparative review criteria, but we don't care what they are.

Furthermore, I would suggest that there at least be one or two members from the TAC who are membership in whatever body takes this forward. Certainly it should not be the whole TAC and I would not want to be one of those members, but to bring that sort of memory of the discussion that's taken place. We've done homework. We've done research. There is a substantial body of supportive information on each of those, some more, some less, but on each of those seven topics or areas that the criteria ought to be developed.

So, I would urge support of the motion. If it could be strengthened a little bit to say, you know, that this is an illustrative list, but a lot of thought has gone behind this list, and that whatever body takes it up ought to have at least some cross membership with the TAC.

MR. BALL: I appreciate the comment. And I guess I would ask that the ad hoc rely on me, if this motion passes, to rely on me to communicate that sense in my report to the Commission next week. Is there anymore discussion on the motion? Hearing none, I would ask for a vote. All in favor say aye. (Vote taken)

MR. BALL: Opposed? (None voiced)

MR. BALL: Motion is carried.

MR. GERALD: I didn't want to vote no on the motion, but I do wish to be recorded as an abstention.

MR. BALL: Terry Gerald should be noted as abstaining on the vote. Okay. I think we can move to discussion of the sub-areas.

MR. STEIGER: Would you like a motion first or --

MR. BALL: Would it be -- would it serve the purpose of moving the discussion on to have a motion?

MR. STEIGER: Go ahead.

MR. BALL: We've got two cards from people who wanted to comment on sub-areas. Moses Whacker from Borgess.

MR. WALKER: Walker.

MR. BALL: Walker, I'm sorry.

MR. WALKER: I'm Moses Walker, executive director, community relations for Borgess Health Alliance in Kalamazoo, and want to just read a statement on behalf of our system there.

Again, thank you for the opportunity to express our views to the subcommittee concerning the proposed sub-areas for determining bed needs at hospitals throughout the state. We are very grateful for the work that has been completed to bring this proposal forward. However, we have some concerns about the proposed sub-areas and how it appears that the stated criteria for developing them have been applied somewhat inconsistently. We suggest that further consideration be given before the proposed new sub-areas are moved forward for approval by this committee or by the full CON Commission.

In reviewing the materials and proposed sub-areas as they were presented to this committee at the November

5 meeting, we believe that there has been a subjective nature to the application of the bed need model for determining proposed new sub-areas, as well as an inconsistent application of stated criteria for determining the placement of some hospitals in the new sub-areas. As an example, for our southwestern region of Michigan we believe that the proposed sub-areas include an inappropriate placement of Sturgis Hospital into the proposed sub-area referred to as 3-A, which also includes the Kalamazoo hospitals.

In the presentation by the Technical Advisory Committee it was stated that it was determined using the data model Sturgis Hospital most appropriately belonged to a cluster within the Indiana hospitals. It was further stated that because of this fact and because there is a desire to reduce the number of single hospital sub-areas, Sturgis was placed with the Kalamazoo area sub-area, even though this determination was not made by applying the data model in an objective manner.

The desire for fewer single hospital sub-areas was stated at the CON Commission Bed Need Ad Hoc Committee on November 5. The rationale for achieving this outcome was the changing nature of healthcare delivery and referral system rather than single provider areas. We would, therefore, follow that smaller hospitals would be placed in the sub-area with larger facilities based on levels of shared market share and referral relationships. We believe that this rationale makes sense. We do not believe, however, that this rationale has been consistently or appropriately applied in some cases.

Since the review data showed that Sturgis Hospital is more related to Indiana hospitals in the referral relationship, we believe it does not make sense to place them in the Kalamazoo sub-area as an arbitrary alternative rather than assigning them to their own sub-area as is the case for Hillsdale Community Health Center and for Community Health Center of Branch County in Coldwater, which are also in our part of the state, as well as other facilities across the state under the proposed new sub-area configurations.

So, due to that concern and others that you will hear perhaps throughout the course of this meeting, we request that this committee either recommend the affirmation of the current sub-area configurations until a more effective model can be developed and applied in a more objective finding, or at the very least, we request the correction of the inappropriate placement of hospitals such as Sturgis and others that may be identified across the state who are inappropriately placed in the newly proposed sub-areas. Thank you for that, for allowing me to make those comments.

MR. BALL: Are there any questions from any of the committee members for Mr. Walker?

MR. HORWITZ: Mr. Walker, have you made -- has Borgess Health System made an analysis based on the criteria that you would think were better of the placement of hospitals in your area?

MR. WALKER: Well, basically, when you look at the sub-area as it currently exists, 3-A, and it is a pretty substantial one now and it contains two big facilities and some smaller facilities there.

MR. HORWITZ: You say as it currently exists, you don't mean the ones that are in effect, the proposed 3-A?

MR. WALKER: Not the proposed one. The one that is currently in effect there. Then as I look at the proposed sub-area, it's kind of amoeba shaped. It goes all the way from southern St. Joe County, and then goes all the way north almost to northern Barry County, and brings in three new facilities, being Sturgis, Three Rivers, and Pennock.

So, the question still just becomes in terms of we would like a better understanding of the rationale for this. Why are we expanding and look at it from a consistency state. As I go down to the southern border I see in Branch County that Coldwater stands alone. I see that in Hillsdale County, Hillsdale stands alone. So, then if you're following- trying to find a reasonable rationale, why would that same rationale not be applied in this particular instance?

MR. HORWITZ: I think you make a very good point, at least as I sat there and listened to this. I had heard the presentation that people made on the TAC that looked at all the data. We can hear from them today.

MR. WALKER: Thank you.

MR. BALL: Also I have a card from Jim Budzinski from Sparrow.

MR. BUDZINSKI: Good morning. Thank you, Mr. Chairman, for recognizing me. And first I have a couple of opening remarks. First of all, I want to say I'm sorry I wasn't here in person last time. I understand a letter I wrote was read into the record and may of caused just a little bit of a stir. That wasn't our intent. I couldn't be here in person to explain it, of course. I had some other conflicting responsibilities. So, my apologies. I appreciate your willingness to hear me in person today under the circumstances.

And I would also like to say thank you for TAC committee work. They are working hard on this very important subject. Sparrow supports the work that you've done. I have to tell you that it's very important. Healthcare is a lot different today than it was 30 years ago when HSAs were first established, and the sub-areas came after that. We are interested in redefining how you approach assessing needs in the communities in our state, in the regions in our state. So, we do appreciate the work in support of that that's currently being done.

Not having the benefit of the draft December 1st letter from the TAC to Mr. Ball, the chairman, I did have some prepared remarks. I'm going to pass them out now. I don't intend to read them like the last time. But here you go. But I'll try to cover the concepts in it and take into
consideration this draft letter.

I would say that probably based upon what I'm reading in the draft December 1st letter, we probably have some honest points of disagreement. Probably in the area of looking at the HSAs. And probably whether or not it's allowable or not under the current law and whether the current HSAs are reasonable. We probably just had some honest points of disagreement on it. I'll comment on that in depth in just a moment.

Beyond that, we have other concerns we raised last time we were here and if you read some again in this letter here that's being distributed, but we characterize those concerns that could be attributable to a number of factors. Our misunderstanding of the proposed methodology. Miscommunication on some technical points in this complex area. They could be also, though, further points of disagreement.

One of the difficulties we have in this complex area is just really getting our hands around what is the methodology. The CON Commission in its past standard setting process has created very detailed narrative models of how regulations are going to be applied. They become very detailed. They're narratives. They explain things. Then the process, the due process allows for some very significant fly specking on virtually what every word means in some of these regulations.

One of the difficulties we're having is that the methodology here is so complex in nature, alpha letters and generations and all this kind of stuff, that we don't really have a narrative, a detailed narrative that you can actually read, understand, see how all the details fit together, and it's probably leading on our part to just some confusion, some misunderstanding, potentially some miscommunication. We have staff people attending these TAC meetings and we appreciate that willingness to allow nonTAC members to join those meetings. And people take notes and sometimes notes are misunderstood and all that kind of stuff. So, we probably have some honest points of disagreement. We probably have some other concerns that might be nothing more than miscommunication or misunderstanding, or may be further points of disagreement, I don't know.

With respect to honest points of disagreement, the HSA aspect. I don't want to run on this for, you know, 10, 20 minutes, but looking at HSAs has been an advocacy role of Sparrow not in the last month, but in the last couple years. As we looked at various studies coming out, whether it's the Dartmouth Atlas or whether it's the Blue Cross Dartmouth Atlas and things like that, it's pretty clear that what we all know is true has happened and that healthcare is different today than it was 30 years ago and the regionalization of healthcare services is different today than it was 30 years ago.

So, our health system board about 18 months ago actually passed board approved guidelines to advocate for looking at revising HSAs. So, while it may be new to you that we're bringing this up from our health system perspective, we've been advocating review of HSAs for some time. We think it probably should follow some sort of objective criteria, probably should look at such things as the Dartmouth Atlas or Blue Cross Dartmouth Atlas as examples.

So, I apologize for bringing it up in this fashion here, but it's something that we've been advocating or sharing with the elected officials, sharing with appointed officials, et cetera, for the last 18 months. And our belief is that HSAs should be looked at.

Our belief is that -- while I'm not an attorney. We haven't had attorneys look at this-- it probably can be reviewed without conflicting with the statutes. And we think that they should be looked at prior to looking at sub-areas because it's an effective way to start in a broad macro sense.

I do note that in the December 1st draft letter to Mr. Ball there is a statement here that HSAs -- the TAC concludes that HSAs are reasonably configured. That's actually some new information because while I wasn't here at the last committee meeting, I did have a chance to look at the transcript. Some of the written transcript statements didn't necessarily conclude that it was a-- HSAs are reasonable as currently configured. That's a new kind of concept that we probably just have a point of disagreement on.

I don't want to necessarily, I mean, take questions on that aspect, but I would advocate for looking at healthcare on a regionalized basis with updated methodology, starting at HSAs. We think that's a good approach prior to subdividing areas to try to address a need.

With respect to the rest of the process and this lack of a written kind of narrative that kind of details CON regulations and such, if we had such a thing perhaps issues like Mr. Walker pointed out, issues like we pointed out about methodology, what is the methodology, how is it going to be applied when there are exceptions, how are exceptions to the methodology resolved, what's the rationale for those exceptions, that would probably just be helpful. Our note-taking ability is only as good as it is.

For example, Stan Nash indicated that only two alpha levels were used, 22 and I think 25. Our notes from the meeting, TAC meeting suggested there were three or four different alpha levels. We could be wrong. It's just - it's hard to get our hands around exactly what the information is. And we kind of recommend, quite frankly, that a narrative be put together in such detail that everyone gets a chance to read it, understand it, look at it, understand when exceptions are made, understand all the decision rules, see if it hangs together in a reasonable, objective fashion. That's probably the gist of our comments.

Lastly, even though I wasn't at the hearing and this meeting, those two kind of fundamental comments. I'd be glad to take any questions.

MR. BALL: Any questions from committee members?

MR. HORWITZ: Since Sparrow Health System has looked at that, have you developed your own thinking as to what the right HSA configuration should be for at least your part of the state?

MR. BUDZINSKI: We have not developed our own criteria. What we do see is other objective supports of analyzing trends in medical care being published and being available and that perhaps those would be good starting points. Dartmouth Atlas, which looked at Medicare data. Blue Cross Dartmouth Atlas, I think an example of that was attached to our comment letter last meeting. We would say that those are probably very good supports of a starting point. A lot of work was done in those areas. I'm not a scholar on those analyses of patient referral trends, but it seemed logical to us that those would be good starting points how to look at healthcare and how it's delivered in the state.

MR. HORWITZ: Those are more analogous to the sub-areas if you are looking across the state, the Dartmouth Atlas.

MR. BUDZINSKI: Difficult to say. They don't appear to be sub-areas, although they appear to be more numerous than the current HSAs, I would agree with that.

MR. BALL: Any others questions?

MR. BUDZINSKI: Our recommendation at the end would be that this particular aspect of the TAC committee be deferred from being voted on by the Ad Hoc Committee until this kind of detailed narrative analysis was prepared and disseminated so everybody had a chance to read the methodology and words in detail.

MR. HORWITZ: Then I do have another question. At the November 5th --

MR. BUDZINSKI: Yes.

MR. STEIGER: In this same request from the department at the November 5th meeting of the ad hoc, there

was this document that runs almost 40 pages. Have you reviewed that and determined that you don't think that's an adequate description?

MR. BUDZINSKI: Yes, I have reviewed that. Several of us in our organization have reviewed that. It doesn't appear to be sufficiently detailed to really clarify decision rules, rationale thinking, justification, like typical CON regulations would.

MR. HORWITZ: Do you find CON regulations clarifying and explaining what they're doing?

MR. BUDZINSKI: I find them very detailed in nature, they are technical in nature, that can allow a person to go from point A to point B to point C, at least more recent regulations are. I'll take further questions.

MR. ZWARENSTEYN: Lody Zwarensteyn again. Are you thinking the HSAs as they apply to the acute care hospitals? What about the other covered services under CON like long-term care, where it's not a matter of service areas and HSAs? You've got county boundaries as the defined service area, and groupings of those then are the HSA, which are then the same HSA for acute care, psychiatric care, and so on. Are you suggesting different HSAs? Are you saying all of them should be thrown out in favor of something that your board would feel a little more comfortable with somehow?

MR. BUDZINSKI: It's not what our board would feel comfortable with. The HSAs were developed a long time ago for acute care settings and I would include everything with the exception of long-term care or nursing homes.

MR. STEIGER: To follow up, would you want different HSAs for those type of services so you would have different HSAs?

MR. BUDZINSKI: We haven't frankly given thought to that particular aspect.

MR. STEIGER: That's what I thought.

MR. BUDZINSKI: No, but this group here, best I know, was only looking at acute care beds as defined. So, in that context we haven't commented on or proposed anything with respect to nursing homes, for example. We thought it was beyond the scope of this group.

With respect to how many HSAs or how they should be structured within the state for acute care beds, our only observation is that the HSAs were established a long time ago when things were a lot different. There's new studies out there that are published, that they are arguably objective in nature, and that perhaps those should be looked at to update the HSAs. We don't know whether 8 or 2 or 12 or 20 are the right answer, but it seemed like that would be a good starting point. That's our only point. It seemed like a good starting point.

MR. MILLER: Are you saying that there are studies -- this is Adam Miller -- that compare hospital organizations and referral patterns from 30 years ago with today?

MR. BUDZINSKI: I don't know if there are things that compare 30 years ago to today, but there are studies. The Dartmouth Atlas, the Blue Cross Dartmouth Atlas, which attempted to look at how healthcare was being delivered in the state. So, there are objective studies in that area.

MR. MILLER: But the relationship between 30 years ago and today, you're not saying there is anything making that argument, that today -- that the methodology that the TAC has brought forward is so far out of date that -- you're not making the specific claim that the methodology as presented is so far out of whack with how things are done today that it should be tossed out? You're not saying that, are you?

MR. BUDZINSKI: I would say that healthcare is a lot different today than it was 30 years ago.

MR. MILLER: Of course it is.

MR. BUDZINSKI: Technology and services and how healthcare has become more regionalized. I would say your community hospitals in the past in small rural areas were considered full-service hospitals. I think today there's regional referral centers that are broader in nature than perhaps the past was allowed to look at.

MR. MILLER: Of course it's changed, but just because it's changed doesn't mean that the methodology that we're talking about -- you know, which I'll point out I was scanning through the minutes from the last meeting and the research director of the Michigan Hospital Association said it's the best that's out there, and it was the best 30 years ago or 25 years ago or whenever it was developed. They surveyed a bunch of state planning agencies, so kind of an objective standpoint. We looked around and couldn't find anything better. And it's the considered judgment from certainly the TAC committee that it's pretty darn good. I don't see what's unreasonable about that.

MR. BUDZINSKI: We probably have a good honest disagreement of opinion with respect to whether or not current HSAs are reasonable or not. Based upon the draft December 1st letter it was a little bit surprising for me to read that the HSAs are reasonably configured currently. My read of the testimony from the last meeting was that a representative from MDCH clearly indicated that it was not necessarily agreed methodology used today, but they were stuck with it. I also understand from the transcript last meeting that other members of the TAC commented and testified that it creates major constraints -- the current HSAs, you know, have major constraints with respect to addressing this need issue. It's difficult for -- maybe as I said, maybe there's miscommunication at times or misunderstanding, but they also might be a good honest points of disagreement.

MR. STEIGER: You indicated Sparrow has been looking at this issue for up to two years. I could ask what the original impetus was for this examination? It's rather an obscure point in terms of state regulations.

MR. BUDZINSKI: Sure. Yeah. Probably 18 months ago or so, maybe about 18 months ago, there was a lot of, a lot of concern about Certificate of Need law in this state as you might recall, and as Certificate of Need law and the issues were being discussed quite openly with the winding down of the last administration, our board concluded that it should have some -- a framework, some guidelines that they could educate elected officials, department officials, other stakeholders about Certificate of Need.

So, our health system did develop some guidelines regarding Certificate of Need. Those guidelines first and foremost say it's a good system. Certificate of Need is important for this state relative to the scarce resources and high cost of technology. There needs to be systematic way to rationalize and approach significant technological investment.

Under that framework of developing some guidelines that our health system would advocate for, one of them was to relook at how HSAs are defined. This was coming right after the Blue Cross report on the Dartmouth Atlas from Michigan Healthcare. It was about that same time, maybe 18 months ago, I don't have it exactly right, but maybe 18 months ago Blue Cross issued its Dartmouth Atlas for how care was being delivered. Based upon that review, our understanding of our region, that we said, you know, it would be good if somebody looked at this for redefining how healthcare has become regionalized for the purpose of looking at the various factors of service. It was in that context about 18 months ago. Does that help?

MR. STEIGER: I guess in that same context, this committee has been meeting for two years probably.

MR. BUDZINSKI: Okay.

MR. STEIGER: We tried to run a very open process.

MR. BUDZINSKI: Yes.

MR. STEIGER: We invited anyone who cared to participate. And I guess I just find it interesting that your board was going through this process and reviewing some of these issues and you weren't able to communicate those concerns, legitimate concerns perhaps, maybe not, but you weren't able to communicate those concerns with this committee, which has been meeting, as I say, on and on and on and very openly, so.

MR. BUDZINSKI: In connection with that, first of all, I hope you won't think less of me that we are exercising our option to publicly comment on proposed rules, that I think that's an opportunity that everybody deserves. With respect to the informal process, it's very difficult to understand two years of effort, the ebb and flow of information, et cetera. We had representatives attend your TAC meetings and we appreciate that. It was very difficult to gauge the ebb and flow of what the outcome is and where the thought process is and, frankly, it wasn't until recently that we really understood that subareas were going to be to some degree redefined, to some degree moved.

So, it's only at that stage where you start seeing the information and say, wait a minute, if we're going to do that, as opposed to looking at bed need based upon occupancy standards and types of subdivisions of patients, then maybe we need to look at HSAs, too. Frankly, up until recently we probably really didn't understand -- quite frankly, our fault -- that it looked like the sub-areas were within your purview as a TAC committee. Our mistake at times.

MR. HORWITZ: If you're confused, I'm really confused. The current CON review standard as adopted by the Commission last March, and you apparently looked at these pretty carefully because you defined them so clear, that said that the sub-areas had to be -- the sub-areas needed -- were to be updated and that the Commission was to approve those actions by November, by six months later, which turns out to be November. So, that was the -- and the review of the sub-areas is, in fact, a key part of the charge to this ad hoc, which it asked the TAC to do or the Commission to approve that. So, the key part of all this is the sub-areas.

What I find notable is that we haven't heard any comment yet, except Mr. Walker from Borgess, about the sub-area assignments. In response to your letter there are some people who looked in your area and said, let's assume that the sub-areas, the HSA restraint didn't exist. Let's just forget about it and then let's look at what the referral patterns would be based on the MIDB for how to group hospitals into sub-areas. And it's on that basis it was determined, and reported to us this morning, that it wouldn't have made any difference for the way the sub-areas came out, to wit, that the two Livingston County hospitals, one in Brighton and one in Howell, are now linked with Ann Arbor because that seems to be where people go for service most. They don't stay in Livingston County according to MIDB as reported to us this morning.

So, that's what I'm concerned about just to point out to you, that any you would know about this issue had your very able associates sat in on the TAC, at least the last few meetings, but that's our clear and explicit charge is to update the sub-areas. And the Commission itself by standard has to update these sub-areas and those standards have the effect of law.

The department has indicated through Mr. Christensen's concerns, but hasn't ever at any of these meetings come forth with any suggestions on how to do it differently. So, I can't speak to that. So the TAC and this ad hoc as agents of the Commission made judgment that the outstanding methodology seemed to be better than anything else available, and it's not terribly different than the underlying methodology of the Dartmouth study. We had Dr. --

SPEAKER: Griffith.

MR. HORWITZ: -- Griffith come in who explained the arcane differences between the Dartmouth methodology and this methodology and they weren't really significant.

MR. BUDZINSKI: It's difficult to respond to statements as opposed to questions. Did you have a question?

MR. HORWITZ: I suppose my question is, are you happy with the sub-area assignments? That's really our assignment today. And there are three areas which the HSA boundaries were crossed. Those were used as a guideline to do methodology, but they were checked against the MIDB and referral pattern. There are three instances that don't conform with HSA boundaries and there are instances in the new proposed sub-area assignments. Are you content or not content with the sub-area assignments? That's what we have to act on today.

MR. BUDZINSKI: Content is an interesting word, or happy. Our framework is that probably -- our framework is the cart before the horse, that the sub-area reassignments probably shouldn't be done until there is a good look at the HSAs in the state because sub-areas are a subdivision of something larger. So, it's the cart before the horse.

MR. HORWITZ: What they are subdivisions of are the whole state. What I just tried to share with you is that the sub-areas are not necessarily subdivisions of the HSAs. HSA is a geographic boundary. You've drawn a line on the map. The sub-areas are, in effect, referral patterns, that's what was used. So, maybe you misunderstood or confused the role of HSAs are not --

MR. BUDZINSKI: Clearly the sub-areas are clearly identified as being subdivisions of HSAs, I mean, because they're labeled as such.

MR. HORWITZ: That's what I'm trying to tell you, the sub-areas -- I thought that's what you were trying to say. That's what I'm trying to tell you, in the current set of sub-areas and the proposed ones there are two or three instances each in which they cross over HSA hospitals.

MR. BUDZINSKI: Our point is that in the broadest sense while that may be true for technical geography versus patient area, our point is that regionalization of health has occurred in the last 30 years significantly more so than just simply looking at the sub-areas, that is the defined level that's been chosen at that time. We think looking at a broader level is a more appropriate framework at this juncture.

MR. HORWITZ: You would tell the Commission to ignore the standard that says they're supposed to take action within six months and proceed on the more deliberate course you propose?

MR. BUDZINSKI: I am not a legal expert as to what the Commission needs to do or should do or has to do, but I would say that just because there is no change does not mean that they weren't updated. If this were a proposal, no change in sub-areas would be an update arguably. Updating can be reaffirmation I would presume. I'm not an attorney. So, other people have a better understanding of what is legally required by the Commission to do what.

MR. BALL: Okay. I think the points are made. So, thank you.

MR. BUDZINSKI: I appreciate the opportunity. Thank you.

MR. BALL: Prior to the start of the meeting this morning it was indicated we might need to take a break. We'll continue on. Amy Barkholz from the MHA.

MS. BARKHOLZ: I wish my name was shorter, I could do this faster.

MR. ZWARENSTEYN: You want to swap?

MS. BARKHOLZ: I already traded it in. I don't want to swap. I am Amy Barkholz from Michigan Health and Hospital Association. I want to make some comments, because we've had a few hospital folks come up and raise some concerns, just to clarify where MHA stands in all of this.

First of all, we appreciate the work that both this group and the Technical Advisory Committee have done. You know, many of the members of the committee are also members of the MHA. They're the people who I turn to when I have questions about details and other technical issues. So, clearly, it's made up of a good group. We've also been a part of the technical advisory discussions. I have participated at times, but more importantly, Bob Zorn has because I don't understand Stan's algorithms at all.

But I just want to make it clear that although we've offered advice and opinions, we don't yet endorse or oppose the sub-area recommendations. We're mindful of the comments raised by the folks here before, the hospital folks. We think that they raised some good points, points that deserve some consideration, and I just want to make clear that the MHA is neutral at this point on the sub-area assignment recommendations, but that we encourage continued open dialogue on the issue. Thanks.

MR. BALL: Any questions for Amy? Thank you. Sean Gehle.

MR. GEHLE: Sean Gehle. Good morning, Mr. Chairman and members of the committee. My name is Sean Gehle. I'm director of public policy and I wanted to make just some very general comments on behalf of Ascension Health of Michigan, including Borgess Health Alliance, St. Mary's Saginaw, St. John Health System, Genesee Health System, and St. Joseph Health System. You've already heard some of the comments from Borgess and we would certainly be supportive from the Ascension Health perspective on some of their concerns.

Essentially we wanted to thank the Technical Advisory Committee and this body for all of its work. We recognize there has been a lot of work put into this. We have been involved in that work. We had representatives of the TAC and representatives on this committee. So, we appreciate that.

I guess with respect specifically to the proposal, we have some concerns with the proposal that's being

forwarded to the CON Commission. We don't believe that the sub-area reconfiguration adequately reflects population shifts. This can probably most be seen in southeast Michigan.

Secondly, we have a concern that we don't believe that there are any geographical boundaries that are in the methodology. And third, we have some concern with the multiple alphas that were being used and the different algorithms that were being run. And I, like Amy, am not an expert at algorithms, so please don't ask me any questions with respect to the exact methodology. But I just wanted to go on record on behalf of Ascension Health of Michigan just expressing some concerns with the proposal you're moving forward, just to go on record.

MR. BALL: What was your second point again? I caught the sub-area not adequately reflecting population shifts and your example was southeast Michigan. What was the second one?

MR. GEHLE: The second one was we question the geographical boundaries that are being used within the proposal, whether or not they're adequate. You know, certainly, we have reviewed the proposal with respect to the HSA boundaries and sub-area boundaries. But we still have some questions with regard to whether or not the geography that's being included in the proposal is adequate.

MR. BALL: When you say you have some concerns, do you have suggestions for changes? I mean, what would you do in southeast Michigan or, you know, what would you do in response to these geographical boundary concerns?

MR. GEHLE: I think some of those suggestions and ideas and concepts have been forwarded by our membership on this committee. So, I think you had opportunity to hear some of that. But I guess I would defer if there are specific suggestions, I note St. John's Health in particular with respect to the southeast Michigan region had some specific concerns with respect to geographical boundaries. I guess I would defer. If you have not already had a chance to hear some of those, there are representatives on this committee. I can get back with you on specifics though. If you're looking for specifics, I will provide those to you.

MR. ASMUSSEN: Bob Asmussen, St. John Health. The issue primarily with the second point relates to the fact that there are no geographical boundaries with sub-areas in contrast to HSAs.

MR. ZWARENSTEYN: Would you prefer political boundary lines or something that you could actually draw on a map, you're on one side or the other and it makes a difference?

MR. ASMUSSEN: I would be happy to answer if we should debate it. Bob Asmussen again. Some of the other methodologies used in other states which, in fact, Ascension submitted for consideration, do, in fact, have political boundaries. And, in fact, most other states use counties. And to the extent a county has a very high population, then those counties are divided two and three ways based on highways, rivers or whatever. And that would bring at least a better framework if, in fact, you wanted to use sub-areas. But I think the point Sean made earlier, number one, is the fact that the HSA is a blank configuration that particularly responds to the fact that systems now serve regional markets and sub-areas make not a lot of sense, particularly when some 65 percent or perhaps more of the hospital beds in this state
are owned or managed by systems.

MR. BALL: Are there any other questions for Sean?

MR. GEHLE: I guess I would just conclude by, you know, I think, you know, that can be extrapolated across the state not just southeast Michigan obviously because we represent hospitals throughout the state. I think we see some of those same issues obviously throughout the state in different regions. So, thank you very much for the opportunity to address you.

MR. BALL: Liz Palazzolo. I assume that you're commenting on the same topic?

MS. PALAZZOLO: Yes. I, too, would like to commend this group. Certainly a lot of effort and time has been spent by TAC in developing these recommendations on sub-areas and I know that all of that takes its toll on people.

I would like to just comment on some of the statements by the representative from Sparrow, which I think have a lot of merit. In particular, I do believe that a summary of the methodology would be very helpful. I know that

there are bits and pieces out there. And actually just Barb Jackson just shared some of the information that you may already have with me this morning and I found it very helpful to go through that and understand the steps that have been taken to kind of get to where you are today. So, I think that would be very beneficial for the Commission to have and also for the attendees at the next meeting if this is going to be presented at that point.

I also think that it would be important if there are any exceptions to the methodology that the TAC looked at, that those be clearly described and how those were approached I think would be very helpful, whether it's with respect to different alpha levels or different areas or how hospitals were grouped together. I think that would be important to know. In other words, anything that was subjective in nature versus simply cranking through the methodology I think would be helpful.

And I know that time is very short, but if that could be available in advance of the meeting, if this is going to be presented at the Commission meeting, I think that would be much appreciated by all of the attendees.

MR. BALL: Are there any questions for Liz? Thank you. Penny Crissman.

MS. CRISSMAN: Thank you very much. Penny Crissman from Crittendon Hospital. I do not have a position yet on the sub-areas. I will be taking this back and they would wish to review. I do have a question though in following all of the legislation last year at this time for the CON, that the intent -- my understanding of PA 619 is the intent of the Legislature was to have you look at the population shifts within the state, and in particular in southeast Michigan and access. And I was wondering, I don't see where that has played a part in this and have you satisfied what the Legislature had intended? Thank you.

MR. BALL: Larry.

MR. HORWITZ: Penny, if you could just stay with us.

MS. CRISSMAN: Sure.

MR. HORWITZ: I know of no provision in Public Act 619 that has any reference at all to this topic. The place where this comes up is in the action by the Certificate of Need Commission in the revision of the bed need standard. Some of your staff can give me a copy of the current standards. I can read it to you. There's nothing in Public Act 619 that directed anyone to look at population shifts or sub-areas or HSAs or anything like that.

MS. CRISSMAN: I'm sorry, I don't have the PA, I don't have it before me. I thought, though, I had read it asked you to -- asks the CON Commission to review access to healthcare issues and part of that had to do with where the population -- am I wrong? I must be totally wrong.

MR. HORWITZ: The phrase about the Commission should look at access as a significant part of its duties is the same words that's been in the statute since part 222 was established in 1988. Public Act 619 made no changes in that.

MS. CRISSMAN: Okay. I apologize for that. I was talking to the chair of health policy, and he was indicating to me that that is what they were looking for from the Commission. So, we must be in error.

MR. HORWITZ: If they were, they didn't write it down in the statute.

MS. CRISSMAN: Okay. Sorry. I apologize.

MR. HORWITZ: But in terms of the sub-areas assignment, all right, the standards which took effect, it's the Commission that directed this group to go ahead and come up with revamping the sub-areas in light of population shifts and it's the Commission that did that.

MS. CRISSMAN: The Commission did that?

MR. HORWITZ: And we looked at the language of the standard pretty carefully and it's that which tells us we're supposed to do these- the methodology and the sub-area assignments.

MS. CRISSMAN: Then let me ask you the question, we are talking about population shifts in some form and did this committee look at that?

MR. HORWITZ: Sure, because what we did is we took instead of the data the population projections were used -- the most recent data, the most recent underlying part in terms of dealing with the sub-areas took into account the population projections for I think it' s 2005 or 2006.

MR. NASH: Based on the current census looking at the population projections as broken down not just by gross population, but by cohorts, zero to something, 21 to 24, splitting it up. It' s not looking at it by total population, but also by age cohorts and including older people tend to use a lot more inpatient care. So, that was looked at very carefully and was very much part of what we' ve been doing.

MS. CRISSMAN: All right. Thank you.

MR. HORVATH: The one reference that could have been made by the policy chair was the 203 or 209 Sub 9 where the Commission had to look was bed movement going to impact access to care in delivery, that' s what they did under that. That was under --

MR. HORWITZ: I think that was in relationship to that special CON exemption 18 for 203. That related to the decision they were supposed to make by mid June on whether to block or not block the relocation -- the creation of two new hospitals in Oakland County. It was in that very specific area.

MS. CRISSMAN: Just in that narrow area.

MR. HORWITZ: Yeah.

MR. HORVATH: That' s the only language that talks about access to care and patient care delivery. Under Subsection 9 they were to make a decision on Subsection 3 and the bed relocation.

MR. HORWITZ: That was all related to hospital bed relocation. Particularly St. John and Henry Ford had a proposal, which the Commission, as you recall, ended not taking action on.

MR. BALL: Mr. Meeker.

MR. MEEKER: My name is Bob Meeker and I was a member of the TAC and I would like to speak in that regard. And at the risk of going beyond my area of expertise, I would like to address some of the concerns that have been raised about the methodology and I will count on my friends, Mr. Nash and Mr. Zorn, if I go too far afield.

First of all, I would like to explain to you that the sub-area methodology that after careful consideration the TAC selected is the same methodology that' s in the standards now. It is not written up in detail in the standards. It is, however, summarized in the document. And I don' t have a color one, but the document that was distributed last time. Mr. Nash went to great pains to take this, I don' t know how many pages there are here, 50 page document or more and try to summarize it in eight or ten bullet points that people could understand. There is very detailed documentation of this methodology that anybody who cares to wade through, not I thank you very much, can do.

And as I said, it is summarized. If there are points that are not clear in the summary from last time' s report, I think the TAC would be very appreciative of assistance in making it more clear and more audible because it is certainly our intent for people to understand what we did and certainly not to cloud the issue.

It is true that currently and under the proposal from the TAC, the sub-areas do not have geographic boundaries. This is a good thing. The reason it is a good thing is that people don' t stay within geographic boundaries. They don' t stay within counties. We had a little bit of discussion a few moments ago that maybe we should go back and do the county boundaries in this state. They' ve been around a long time and things have really changed since they were set up. But --

MR. STEIGER: Excuse me, they never did change.

MR. MEEKER: They don' t now, and our proposal does not have geographic boundaries.The reason this is a

good thing is because for each and every zip code that a cluster of hospitals draw more than a minute number of patients from, they collect a piece of the bed need from that zip code.

An example -- I'll use an example that does not affect my organization, which is Spectrum Health, which is Munson. There are a lot of us from the lower 48 who spend time up in Munson Medical, up in the northern part of our state. Some of us may have to go to a hospital. I would imagine that Munson Medical Center enjoys a small piece of the market share and, therefore, the bed need from all the -- from many zip codes across the state. This is a good thing because it reflects how people seek care.

So, the fact that there are no -- you can't draw the boundaries of the sub-areas, this is true. The only thing that you've got on your report is little bubble diagrams that my colleague at Spectrum Health spent a great time putting together, that shows which hospitals are clustered together. But I would see this as a strength of the methodology and not as something to be criticized. If anyone has any questions that I can answer, I would certainly try.

MR. ASMUSSEN: Bob Asmussen, St. John Health. I want to ask you a hypothetical on your point. Let's assume that Novi and the surrounding communities grow to 500,000 people in the next ten years. Under this methodology with no geographical boundaries, there will be no bed need for that community, is that correct? Is that good?

MR. MEEKER: There will be no bed need in that location. There will be bed need in the area that those --

MR. ASMUSSEN: Does that make any sense in terms of access?

MR. MEEKER: I think it does because if there is a net bed need there are provisions in the standard for establishing a new hospital and going through a process of assigning that new hospital to an existing sub-area. So, that, you know, I think that is carried forth. That is not to say that Novi in isolation without consideration of where people are going is going to show a bed need, that's true. But those people are not just dying in the streets because there's not a hospital in Novi. People are being taken care of now and they are demonstrating a bed need. And if, in fact, a net need in the general area is determined and a hospital is built in Novi, that hospital could be assigned to the appropriate sub-area. And I will defer to Stan to make sure that I am stating that accurately.

MR. NASH: Fine.

MR. ASMUSSEN: Currently, just to go on a little bit further, sub-area 18, which is the Oakland County, essentially Oakland County sub-area minus Botsford, suggests an overbedding of 715 beds underneath the new methodology. All of these institutions are on the eastern side of the county, none are on the western side of the county. There are none on the western side of the county. So in my example the expectation would be over time that this methodology should not be altered, that people who relocate into those suburban areas of the county will always have to seek their care from institutions on the eastern side of their county. Don't you think that is a flaw in that reasoning?

MR. MEEKER: I'm not sure it's accurate. I honestly don't understand the geography of that particular area well enough to comment on whether or not it's a good idea or not.

MR. HORWITZ: Larry Horwitz. My office is in Novi. So, we're concerned about healthcare access if we need it for our employees, including yours truly. I have never understood that Huron Valley was in eastern Oakland County, nor that Pontiac was in eastern Oakland County. So, when you say all these hospitals are in eastern Oakland County, it's not supported by a review of the map.

MR. ASMUSSEN: Chair, I don't want to engage in an old argument. So, I'll stop.

MR. FALAHEE: Mr. Meeker, you raised some issues and I may tap your knowledge and you may defer to others. There was comment from other speakers about potentially different alpha levels being used, whether it's 22 or 25 or 18. I'll ask you the question, were different alpha levels used? If so, why?

MR. MEEKER: The answer is yes. And I really would have to defer to someone with more technical knowledge than I. I mean, the reason that -- one of the thoughts that went into the final alpha levels in many cases, varying alpha levels were applied to the same HSA. The same alpha level was not applied to each and

every sub-area in the HSA. There's not differences in HSAs, but because of the complexity of the HSAs, because of the number of hospitals, and because of one of the decision rules which is very explicit in our report, you could argue with it, but it's very explicit, that we don't have more sub-areas than we've got now. We thought that the number of sub-areas now was about right. We want the same number of sub-areas or fewer. As Mr. Horvath has indicated, we ended up with seven fewer sub-areas across the state. So, for that reason, yes, varying alpha levels were used in order to try to accomplish that.

MR. FALAHEE: But within an HSA, the same alpha level would have been --

MR. MEEKER: That is correct.

MR. FALAHEE: Another question if I may regarding single hospital sub-areas, and we talked about Hillsdale versus Coldwater versus Sturgis. Can you explain the rationale why some are single hospitals and others are not, or do you need to defer on that? If you need to defer.

MR. MEEKER: I can try and I'm going to keep glancing over at Stan. As far as I can recall, Coldwater clustered as a single hospital sub-area all by itself. So, the methodology ran and that one fell off as a legitimate sub-area hospital. Incidentally, I should mention to the group, and I think it was brought up last time, that for virtually all the sub-areas, and certainly all of the ones that were in the least bit questionable, our representative from Michigan Health and Hospital Association brought market share maps of the affected hospitals to -- somebody might say, let's use Hillsdale as an example. Hillsdale originally clustered with the hospitals in Lenawee County. So, we looked at that and said, this doesn't make sense. And so, we looked at the market share maps and his market share maps, the market share maps from the Michigan Health and Hospital Association, have the advantage of including the Ohio discharges. So, what that means is patients who went to Ohio were factored in.

So everybody's market share in the existing areas went down a little bit because there were more patients being siphoned out. Whereas, the official state database does not have the Ohio patients in it, or at least it was excluded for the purpose of analysis.

So, and in the case of Hillsdale when we looked at the market share maps and realized that the Ohio factor or the lack of the Ohio factor was skewing the data, we could say yes, Hillsdale as it currently is really needed to be its own sub-area and not clustered with Lenawee. That's one where we made an exception and I think that's addressed in the report.

The situation for Sturgis is much -- is similar. I think that the representative from Borgess accurately represented what we did. Clearly Sturgis will be part of a northern Indiana sub-area. We couldn't do that. I think it could be argued that maybe Sturgis ought to be its own sub-area. It did not seem to make sense. I shouldn't say that. It does cluster to some extent, boy, I'm now going to look to Stan, to some extent with Three Rivers and Three Rivers clearly clusters with the Kalamazoo hospitals. So, it's kind of this chain-link effect. I think that the comment is valid, that is one where we did use judgment and, in fact, the 50 odd page document does allow for both an objective portion of the methodology and then professional judgment. Professional judgments can differ, even though the objective methodology is pretty much going to stay the same, as long as you put the same things in. So, that one could be questioned. Not being affected by that sub-area, I would ask the value of a Sturgis only sub-area, but I don't know the area well enough.Perhaps that would make more sense than clustering it with Kalamazoo.

MR. FALAHEE: Thank you very much.

MR. BALL: As I recall, maybe Stan can comment on this, this question of these alphas and so forth, and this is a very layman understanding, but as I recall from the last meeting, a layman's interpretation of your technical explanation was that they had these various alpha levels and you applied them to all of the areas and you found that when it came down to it, there was little differentiation caused by all of the iterations that you went through. Is that not correct?

MR. NASH: This is Stan Nash. The answer is several different alpha levels were tried with every HSA in an attempt to satisfy the first criteria, which was to have no more than the current number of existing clusters. In addition, there were also some other explorations of the data. For example, it became obvious to us very early on that there were -- there were hospitals of referrals, or called referral hospitals. The best example I can give

for this is Marquette General. If you live in the U.P. and you have anything more serious than something pretty simple, there is only one hospital you really want to go to. And we gave an example at the last ad hoc where Marquette General actually has a market share greater than Schoolcraft Memorial's market share in their home zip code because of that fact.

And so, at one point what we tried to do was to increase the alpha levels to the point where we could identify referral hospitals and then group back into them the many outlying community type of hospitals and that did not turn out to be too successful either, and where it failed pretty badly was in the Detroit area. That's where it failed the worse. So, we did make attempts to do away with geographic considerations of HSAs and found them to be nonproductive. So that the alpha levels that were chosen were chosen in accord with that first criteria, and that was that it produced no more than the existing number of clusters and the number of iterations was mainly determined by stability of the computations.

Now, that probably doesn't mean anything to you, but let me give you an example. When you go through the iteration process one time, it will identify one hospital. When you go through it a second time, it will do one of two things, it will either identify a second hospital or it will group that hospital with the first one. And when you go through the third time, it goes on and on. For HSA 1, where the alpha level was a .22, we actually ran 140 iterations. When I ran 180 iterations, or 40 more, the results did not change any and, in other words, the same clustering occurred at the 180 level as it did at the 140 level.

Now then, for the other HSAs where the methodology was applied, that same philosophy was used with the exception of one, and that was southwest Michigan in order to prevent Kalamazoo and Battle Creek from combining. Other than that, we ran -- we, I ran the iterations until the computations stabilized. In other words, you could run them 10 more times or 50 more times and you're still going to come out with the same grouping. And the choice of the alpha level clearly did have an impact on the grouping process, but it was nothing I could control. There is absolutely no control I have over that algorithm by the choice of the alpha level. The only choice that I exercise upon it is how many clusters come out the back end, not who's in them.

MR. STEIGER: Stan, it might be helpful if you defined alpha level. We keep talking about alpha level. But alpha level really is --

MR. NASH: It's really simple. Think it's market share.

MR. STEIGER: Market share. It's nothing magic.

MR. NASH: That's why I said when we tried to identify referral hospitals, we would really elevate the alpha level like they're a .3, okay? Now, a market share of 30 percent in any given zip code, that's a big chunk, okay, and what it would -- what the methodology would do is literally drop out all of the hospitals. It didn't have any kind of a market share of .3 in any zipcode.

MR. STEIGER: Anywhere, right?

MR. NASH: Anywhere. And in southeast Michigan we dropped out what, 15 or 17 hospitals, something like that, even at the .22 level, okay? And that's why we had to have the other back assignment rule that says, okay, you now have the clusters that the methodology created, but you're short some people. So, how do you assign them back into the group? And the decision rules were there for that, which I won't explain unless asked.

MR. BALL: We're going to take one card that we have and conclude that discussion and then break for lunch and continue the debate or hopefully take some action after lunch.

MR. STEIGER: Can I make a motion before lunch?

MR. BALL: Certainly. Mary Beth Milliman from Munson.

MS. MILLIMAN: I'll be brief. But I have a really long name. But no, Lody, I won't switch.

MR. ZWARENSTEYN: Appreciate what you got.

MS. MILLIMAN: I'm Mary Beth Milliman. I'm representing Munson Healthcare, which is located in Traverse

City. I'm also a member of the Technical Advisory Committee. What I would like to speak to is as representative of an outstate hospital. Although many have facilities in out state, one of the real strengths of this sub-area analysis not being geographic, especially around counties, is that we serve -- in our example we serve a very broad geography. 75 percent of our admissions come from five counties. You have to go out ten counties to get 85 percent of our admissions. So, if the bed planning were circumscribed to a much narrower geographic designation, you would, in fact, cause some substantial access issues in most of the State of Michigan. And Stan talked about the U.P., I won't use that again. But I would urge you to consider very seriously the strength of the sub-area analysis in looking at market and patient dynamics as opposed to small geographic areas, although I understand it's very important to the very densely populated and certainly to the City of Detroit. Thank you.

MR. BALL: Any questions? Thank you, Mr. Steiger.

MR. STEIGER: I would move that we approve the sub-area revisions as they're documented in the document that was passed out at the November 5th meeting. The footer on the bottom of the listing of sub-areas is entitled TAC approved 10/31/03. As I said, I would move adoption of those sub-areas.

MR. BALL: Is there support?

MR. MILLER: Supported.

MR. BALL: Supported by Adam Miller. With the motion on the floor, I'm going to recess for lunch. People can think about that motion and what discussion they would like to have take place, and we'll resume at the appointed hour, which is one o'clock.

(Recess taken from 12:00 to 1:00)

MR. BALL: I'd like to call the meeting back to order. There is a motion on the floor. It's been seconded and is open for discussion at this point. I would say that, you know, in the interests of moving things along and being cognizant of people's time constraints, I've heard from a couple of members that they need to leave possibly before three o'clock and would like to be here to participate in the debate and to vote and so forth. So, I would ask that the committee members in carrying on the discussion that, you know, we make points and if there is motions to be made or whatever, they get made, but we not review the same issues over and over and over again. We spent a half hour this morning on something that I thought we all pretty much agreed on. So, I would like to move the discussion along. I don't want to set an arbitrary time limit. I do want full discussion, but I think it needs to be constructive discussion and moving forward. So, that having been said, Dale, I think you wanted to start the discussion?

MR. STEIGER: Well, we talked at the break a little bit about the alpha level and we've sort of agreed we're not going to use the term alpha level. We're talking market share. I think everyone understands market share. The Sparrow folks, who I note don't appear to be here, so they're going to miss this illustrative explanation here, but since they have indicated quite a few alpha levels or quite a few market share levels, minimum market share levels, I thought it might be useful if Stan could just once more walk us through the fact that we had -- I believe we ended up three market share minimums. We are going to include in whatever documentation we end up sending or agreeing to send to the CON Commission, we're going to include a summary of Stan's comments from the last meeting. I think if you recall if you were here at the ad hoc meeting, Stan essentially has gone through the same explanation. We have that summarized on paper and that will be included with whatever goes to the Commission, which is really a repeat. And I would ask Stan to do it one more time for us.

MR. NASH: This is Stan Nash and I am assuming everyone can hear me okay. In the Sparrow letter, which I am referencing, it is stated that I had said at the November 5 meeting that only the alpha or relevance NTC levels of .22 and .23 were used. That clearly was a misstatement on my part. The alpha levels that were actually used were only three levels. There were 28 HSAs that used a .22 relevance index, and two HSAs that used a .25 relevance index, and then HSA 2 used a relevance index of .15. And after I reviewed that and looked at that, I actually believe that that relevance index could be substantially elevated and rerun and not dramatically alter the final results for HSA 2. It was lowered to that level so that Doctors Hospital of Jackson would not drop out of the analysis and show the clustering that you have with Foote. I believe that what will happen, and I will do this to verify that what I am telling you is true, that if I increase the relevance index test level to .22, or somewhere in there, that it will not substantively change the clustering for HSA two. I will

certainly do that before the next Commission meeting next week and if anyone wants to know the outcome of that, you need to E-mail me at Nashs@michigan.gov, and as soon as I find out, I will tell you.

So, in the Sparrow letter please note that there were three -- well, two additional relevance indices listed, which are inappropriate. One is for HSA 4 and the other is for HSA 7. For both of those HSAs it was the professional judgment of the TAC committee to utilize the existing facility sub-area level that was already existing. And the reason that was is because of the extent to which the regionalization of hospital care had occurred in those three areas. I specifically alluded to that in the Upper Peninsula with Marquette and gave you a specific example. Mary Ann Milliman came and gave you a similar example for HSA 7. And for HSA 4 there are two primary areas. One is Grand Rapids, the second is Muskegon, with clearly Grand Rapids being the dominant referral center.

For example, one of the results that we experienced when we were trying to cluster hospitals was that Reed City would cluster itself with Grand Rapids and that didn't make sense, I mean that's the straight and easy of that, because of the physical distance. Now, what you need to know is Spectrum owns Reed City and guess what happens to Reed City patients when they need referral for more advanced intensive hospital care? They go to Grand Rapids. And so, even though the model was telling you correctly what was happening with the market share patterns, it was felt by the planning professionals of the TAC committee that the appropriate structure of the sub-areas in HSA 4 were far more appropriate.

MR. HORWITZ: Stan, question. Are the other numbers on the Sparrow letter, Page 2, that lists what I take it when you say relevance index is what now Mr. Steiger is advising us to all call market share, right, same thing?

MR. NASH: Yes.

MR. HORWITZ: Are the other numbers correct in terms of what Sparrow has listed in its document in terms of the HSA 1 is 22 and so forth ?

MR. NASH: I believe I stated that the market share factor for HSA 4 is -- for HSA 7 are irrelevant.

MR. HORWITZ: I understand but if I put an asterisk instead of the relevance numbers that are somehow in the Sparrow letter, is then the rest of this table correct?

MR. NASH: Yes.

MR. HORWITZ: Thank you.

MR. BALL: Okay. Is there any other comment, discussion, debate, regarding the motion before us?

MR. HORWITZ: Jim, I don't think it's fair for someone who is not a technician to try to define how I think it makes sense, and I wish the technical people on the TAC would help correct me. The alternate proposal I seem to be hearing from Ascension and some others is to use geographic boundaries, lines you can draw on a map, which some states in America use, but we did the research and found many other states don't. And when people were talked to in the states that used geographic boundaries, they said your system is a lot better. We just don't have the manpower staff to do that. It would seem to me incredibly nuts that we would use county boundaries. I suppose the simple way of doing this is to say if somebody thinks the current methodology is out of date and is not reflective in recent trends, the county boundaries in Michigan were established and haven't been changed since the 19th Century. And I dare say we have even more changes in society since then. But a more simple way of just putting it is if I've got a hospital that's, you know, a quarter mile north of the county boundary, it may well be that more of my patients come from south of the county boundary than from north. I use that as an example because that's the question I think Bob Asmussen very properly asked, how come Botsford Hospital isn't in with all these other counties - all these other places. That was the answer we got from people. Their predominant population they're serving comes from south of them. They are like four miles north of Eight Mile Road.

I went through just to see what the difference was and found that there are only four HSAs, excuse me, four sub-areas in the state which don't happen to - just so happen to fall out by county boundaries, and these are Wayne County, where the way this methodology works has Detroit and Grosse Point to the east hospitals together and western Wayne County hospitals together. Macomb has the cluster of hospitals in Warren

together and the rest of the hospitals separate at the north. Oakland County is all together with the predominant exception of Botsford, which is a sub-area with the hospital in western Oakland County, by itself, St. Mary's of Livonia. They seem to be serving a common area. St. John River District, excuse me, what's the name of the hospital on the north end of Saint Clair?

MR. ASMUSSEN: River District.

MR. HORWITZ: River District seemed to have a different catch area than Mercy Hospital in Port Huron and the other hospital is called Port Huron Hospital. The other exception I could find in the state is Ottawa County, in which north Ottawa County is about ten miles from Muskegon, is grouped with the Muskegon hospital and two hospitals that are physically located in Oakland -- in Ottawa County, but they're Holland and Zeeland, are joined in the north.

So, it ends up that by following the methodology that Mary Beth McMillen described earlier of where county -- we're grouping hospitals according to where people go, right? And that would, therefore, show and reflect the fact if a significant number of people live in a small community hospital go to some major referral center for much of their care, that gets reflected. So, that seems to me to make a lot more sense on how we're doing this than saying everybody on this side of Eight Mile Road goes this way and everybody on this side goes somewhere else. We're doing it according to where patients have chosen to go based on medical referrals. And that seems to be what's happening.

Now, the gentleman from Borgess raised the issue about Sturgis, and I think people need to look into that one, but that seems to me what this is. This is not taking an algorithm and running it in a computer and have it spit out something without regard to what makes sense and I think the TAC has done a good job of laying out for people what the methodology was and when as an exercise of professional judgment they chose to make an accommodation. That's why I think they're called the Technical Advisory Committee, most of them. There are some dummies on there asking questions that they explain themselves in English. I'm very comfortable. I want to point out that according to the standards that we're operating under, I kept on referring to that section of the current hospital bed need standards which was adopted in May, said these hospital sub-areas and the assignment hospital sub-areas shall be updated at the direction of the Commission starting in May 2003, which caused this poor ad hoc to come back and start working again with the Technical Advisory Committee. And to be completed no later than November of 2003. People keep on making comments we're under the deadline. The Commission doesn't meet until nine days after. The updates shall occur no later than two years after the official date of the Federal census. That means it's got to be done, 2012, but it's no later than. So, if the Commission found the explosion of 400,000 people in Novi and other amazing things that might occur in life, that could be brought to their attention, which I assume people will know about it if such a phenomenal thing occurred. The updating of the bed need numbers, in other words, taking these sub-areas and then running them through, has to occur every two years. I think we're making progress here. Thank you.

MR. BALL: Thank you for those succinct comments.

MR. ASMUSSEN: I'll try to be more succinct. I think that when you look at what TAC has done here, whether you talk about the current sub-areas or you talk about the tweaking that was done for consideration by the Commission, you can argue both sides of the fence. You can argue Sturgis, you can argue a couple of the others. The point is that at least using this methodology, I think the TAC did a fairly good job of trying to do what was right, beyond what the technical formula would suggest.

However, I will vote no because the methodology has not dealt with the subject of access and the movement of populations. This methodology says that unless there is an institution in a specific geographical area, it has no bed need. So, for those areas within this state that are growing rapidly and where there are currently no institutions, those folks by virtue of this formula are expected to find an institution at whatever number of miles it takes to get to.

Given that the Commission, the CON law, suggests that we have to be concerned about access quality and cost, this methodology fails the first requirement. For that reason, I am not blaming the TAC, I'm suggesting that from the standpoint of St. John Health we're disappointed in not having had the opportunity to deal with the question of access, we failed to do it again.

MR. BALL: Any others questions?

MR. ZWARENSTEYN: Just a comment. I support what Mr. Asmussen says in a sense but I also recognize the most lucrative and stable area within law to practice is in boundary law. There is never -- the same argument that can be used to say we don't have a hospital, you'll never get one in my area, can be used for Podunk, can be used for Hudsonville, Allegan, or Allendale. You can name any city or any community that does not have a hospital and you could apply that logic. And yes, everyone of us wants a hospital on every four corner. We want a fire station there. We want a police station there. We certainly want a fire plug there. But there comes a time when you have to say wait a minute, we have to put boundaries somewhere.

It will never be perfect and I don't know that we would ever be able to get something that's going to meet every little demand. I think part of your argument or concern, and I do support the concern, can be gotten at in other ways, be it relocation criteria or whatever. But just to say that you're not going to be able to put something in a community that doesn't have it right now, then you would have to start defining community, size of community, and you're always going to be in arguments about territory and boundaries, where they are, where they're not, and so forth. And I think we would be forever discussing that.

MR. ASMUSSEN: Lody, something you mentioned, relocation, that is a potential solution, but right now as we well know it's a two-mile limitation. So, that doesn't solve
the problem.

MR. ZWARENSTEYN: I don't think it's cast in concrete.

MR. BALL: Stan.

MR. NASH: This is Stan. The current standards in Section 3 clearly define a methodology for assignment of a new nonexisting hospital to an existing hospital sub-area. The basic philosophy of this section was you have to rob Peter to pay Paul because that is exactly what happens when you have a data set where all of the patients are currently being served, and that is certainly true in Michigan with an average hospital occupancy of 50 percent. Then this section was included so that where there is an established bed need, there is a methodology for defining what sub-area it is to be included in. If you need anymore specific than that, I'll go into it.

MR. BALL: Any other comments? Seeing none, I move to vote all in favor of the motion on the table to adopt and move forward the recommendation to the Commission the recommendations of the TAC, please indicate by saying aye. (Vote taken)

MR. BALL: Opposed.

MR. ASMUSSEN: No.

MR. BALL: The motion is carried. Mr. Steiger.

MR. STEIGER: I would like to make a motion that the hospital bed numbers as distributed this morning by Larry Horvath be approved.

MR. ZWARENSTEYN: I support that.

MR. BALL: It's been moved and suported to adopt the numbers as presented. Is there any discussion on that motion?

MR. ASMUSSEN: Bob Asmussen. I think I know the answer to the question, but maybe for the record it would be helpful to understand the TAC's reasoning. In the development of the bed need, we this time around took out OB and Peds as I understand it. There is also an argument if you're thinking about distinct units of hospitals, that rehab beds and intensive care beds sort of fit the same criteria. And should you be measuring here classical med-surg beds? I would be interested, primarily for the record since I already know the answer personally, the rationale and why you didn't choose to add intensive care.

MR. STEIGER: Stan.

MR. NASH: This is Stan. And, first of all, I want to clarify what you said in that OB and Peds were not taken out. I think what you meant to say was that they have been

separated out as a special part of the methodology.

MR. ASMUSSEN: Yes, I' m sorry. I stand corrected.

MR. NASH: Because they are clearly included in the revised methodology. The methodology to the extent that is possible with the existing data set, we' ve gone about as far as we can go. Let me be specific. It would be nice if we could identify neonatal intensive care beds. It would be nice if we could identify intensive care beds, like coronary intensive care units and ICUs. It would be nice if we could identify maybe neurosurgical units. It would be nice if we could identify probably at least 20 others. But the Michigan inpatient database does not allow us to do that, at least not in a consistent way. And even something which appears to be as obvious as neonatal intensive care is not recorded uniformly by all hospitals. And the fact that those beds are licensed medical surgical beds, the data record that we get does not permit us to separate those out and identify those subunit specialties or it would have been a consideration.

MR. BALL: Any other questions or comments? Mr. Meeker.

MR. MEEKER: Very briefly I would like to clarify the motion. I believe that the motion is to approve the modifications to the methodology, which result in the bed need numbers that you got this morning. There are substantial changes to the methodology. If we just approve the numbers, the methodology has no standing in the standards.

MR. STEIGER: That' s probably a reasonable clarification. We did spend a lot of time changing them. I guess I would like to clarify the motion and change the motion, make it two motions basically. That the methodological changes that we discussed at the last meeting be approved, primarily normative approach going to actual utilization rates and the changes in -- and I' m talking off the top of my head, the changes in target occupancies that we had set up for OB, peds, and med-surg, plus I believe some of the changes in the demographics that will build into the methodology. Basically approve these methodological changes as discussed at the last meeting, and then I would like to offer a second motion after that to approve the numbers that were submitted. So, I guess we need a second.

MS. EBERS: Deborah Ebers. I second it.

MR. ZWARENSTEYN: I thought that' s what you said the first time around.

MR. ASMUSSEN: That' s what Lee heard.

MR. BALL: Okay. The theory is now have two motions before us. Is there any further discussion on the issue of the methodology? I think Mr. Asmussen raised the question, it was responded to. Is there any other question on methodology? If not, we' ll move to vote on approval of the methodology. All in favor say aye. (Vote taken)

MR. BALL: Opposed? (None voiced)

MR. BALL: The motion is carried. Abstentions? (None voiced)

MR. BALL: That motion is carried. Then moving on to the approval of the numbers.

MR. STEIGER: I move we approve the bed need numbers with whatever changes the department wants to make in terms of inventory as licensed and so forth, but that we approve the bed need numbers as generated by the methodology that we just adopted.

MR. ZWARENSTEYN: Second it.

MR. BALL: Seconded by Mr. Lody Zwarensteyn.

MR. HORWITZ: I think the simplest thing would be to say we' re approving the bed need numbers. Under the standards the department always has the right to change inventory. All we're doing is approving the column called bed need numbers. The standards provide that at any given time the department can tell what its inventory is.

MR. BALL: He' s saying that technically the motion is to approve the bed need numbers because the department can technically change the inventory.

MR. STEIGER: I think that' s what I said.

MR. BALL: Okay. Is there any discussion on that? And I have a card from Mark Mailloux from U of M. Is your comment concerning this?

MR. MAILLOUX: In general.

MR. BALL: Okay. Please --

MR. MAILLOUX: You may take the vote, either way. I mean, I can speak before or after the vote. It' s on the topic in general, not specifically this vote.

MR. BALL: Why don' t we have the benefit of your-

MR. MAILLOUX: Yes. Good afternoon, I' m Mark Mailloux from University of Michigan Health System and I was a member of the TAC. We' re all saying this because we' re assuming that the TAC is now, you know, dead, that the stake has been driven through its heart.

MR. STEIGER: Not dead, please.

MR. ZWARENSTEYN: There is life after death.

MR. MAILLOUX: But the comment that I wish to make, I' m a member of the TAC and I support the recommendations that we brought forward and am pleased that the group is adopting them. I am hoping to speak to you for about two seconds on the comments that Bob Asmussen brought forth just a moment ago. And I would like to add U of M' s insistence that while we realize that it is not currently possible to segregate the data into the intensive care pieces, we believe that it is very important to do so. Just as we need to look at obstetric units apart from pediatric units, apart from any other unit, the convertibility of patients from one bed to another at any given point in time is not possible. You don' t put a cancer patient in an OB bed just because you happen to have an OB bed available and an extra cancer patient. That means that an 800 bed hospital may run more as an accumulation of many 10, 15, 20 bed hospitals, with their own varying fluctuations in terms of occupancy and they are not immediately transmutable into some other bed type.

So, we would urge that the Ad Hoc address the fact that this should be put in the Commission' s mind that this needs to be addressed, perhaps there needs to be some encouragement that the data collection be more detailed and more complete, so that in the future this can be addressed because we believe it is a very important part of determining bed need. Empty beds in the unit cannot be considered vacant just because there are patients that can' t get into other units in the same hospital. Thank you. Any questions?

MR. BALL: Thank you. Any discussion on the final motion? Seeing none.

MR. HORVATH: One point of clarification. The discrepancies will not have any impact on the current bed need count, and also, the discrepancy between licensing and the department' s inventory will not create a bed need in any of the sub-areas, just to make that clarification, even after we resolve these few sub-area issues.

MR. BALL: Any other discussion? Seeing none, I' ll move for a vote. All in favor say aye. (Vote taken)

MR. BALL: Opposed? (None voiced)

MR. BALL: None. Abstentions? (None voiced)

MR. BALL: None. The motion is carried. I think that concludes the task before us in terms of making a presentation to the Commission.

Now I think we get to the question Cheryl raised earlier about what the content of that would be. I believe the department sent to me yesterday a draft of a revision of Section 3 and Section 4, and I think I sent that on to ad hoc members, but my interaction with the E-mail system is something else. So, it may not have gotten

there. Brenda does have copies that she can distribute today, and it was predicated on what activity was going on and offers, you know, a suggestion about where we would be going or how it would be presented.

I think my vision is at the commission meeting I would be making the initial presentation talking about the overview, talking about some of the issues that have been raised today that are extraneous if you will to the strict bed need numbers, like the ones just raised by Bob, and the nature of those beds by Bob and Mark, but then I would turn it over to Dale and the other members of the ad hoc essentially to go through the presentation that they did at our last meeting, possibly updated and expanded in light of the comments and commentary, and use that to formulate if you will the presentation to the Commission. So, that's what I saw as a general approach, and you folks from the TAC can make your suggestions as to, you know, how that might be modified. TAC people. Hello.

MR. STEIGER: I certainly think that's a reasonable way to do it. My suggestion would be that the TAC members, those who are so inclined, and there needs to be more than one or two, that we carve up this document that we went through last time so that we have a number of different people making presentations on different sections of it. We certainly need to get together in the next day or two I suppose and make some of those decisions. But that would be my suggestion. Really this is not something we have discussed as a group. I think maybe the committee members --

MS. JACKSON: Will the CON Commission members be able to get copies of the document, the Power Point document before the meeting? I think that's going to be really important. I don't know if those packets have gone out or not.

MR. HORVATH: They will go out, I believe tomorrow. We're just waiting for direction from the committee on what they want us to send. Obviously update the tables, statewide table, and hopefully the language that updates the methodology. But, you know, there will also be indication that you want the presentation included in the packet and does the presentation need any updates from this meeting today?

MR. STEIGER: You say it's going out tomorrow?

MR. HORVATH: We would like it to go out tomorrow. So, we can overnight it to all the commissioners so they can have about a week to review this.

MR. BALL: Cheryl.

MS. MILLER: Cheryl Miller. I think what we originally envisioned was taking the Power Point document that was distributed on November 5th. We already knew there was some tweaks and clarification we wanted to make based on input from that meeting. We now probably have a few other tweaks from today's meeting, excluding the possible inclusion of the 50 page everything you ever want to know but were afraid to ask, the original methodology that is obviously the guts of what Stan has done. If people want to read that and have a little bedtime reading, that's great. We can certainly include that.

We also had originally talked about did we really need an executive summary of that. And based on today's discussion, I am not sure that that is what people want. Maybe they want all the gut, all the details, and all the specifications. Maybe a Reader's Digest version in addition to detailed. We thought about a Reader's Digest version of the executive summary and then the Power Point document, you know, tweaked a bit, and some of the appendices filled in, and then present that to the Commission depending on how much time was available at the agenda.

MR. BALL: I would think that -- Jim Ball. I would think that to get your package out tomorrow in a timely manner you could use the November 5th one with a cover to the Commission members, indicate this is the, you know, presentation made by the TAC on November 5th and is likely to be updated for the session, but that, you know, it provides them necessary background. That way you don't have to have a meeting tonight into the wee hours of the morning to try to come up with a final version.

MR. ASMUSSEN: Based on the fact those 11 people don't eat and breathe this stuff everyday; I would urge that we send the Power Point presentation. And what I would like to know if I'm a Commission member is what did you recommend that is different than what is in place today? And that would be the focus of the executive summary so that they understand what those alterations are. And then they can obviously question members of the TAC, you, as chair of this group. If you send them more than that I think they're going to get-

there will be such a large packet they won't even look at it. So, you've lost them.

MR. BALL: Does that make sense?

MR. HORWITZ: You're suggesting that not to give them the 50 page-

MR. ASMUSSEN: Give them the 50 pages with the executive summary on top that says what is different in this recommendation than existed before.

MR. HORWITZ: I think that would be good. I think you do need to give them the list of the bed need numbers by sub-area because that's technically what they adopt as the appendix.

MR. ASMUSSEN: That could be part of the new --

MR. HORWITZ: Part of the new and better things.

MS. MILLER: This is Cheryl. That's one of the placeholders in our appendix.

MR. STEIGER: I think it's a good point. We can probably pull something together tomorrow morning and get it to you electronically.

MR. HORVATH: Right now we're going to provide the tables, the bed need statewide numbers, the actual Griffith paper, the Power Point presentation, and then hopefully by tomorrow a one-page executive summary.

MR. STEIGER: I think the executive summary, as I'm hearing from Bob, would contain both the sub-area definitions, whatever number of pages those are, plus the new bed need numbers, that would essentially be the summary. I don't think we need to go into methodological changes or anything.

MR. ASMUSSEN: That is correct.

MR. STEIGER: That's the bottom line. So, it would be more than one page.

MR. HORWITZ: I do think you need an executive summary that's in one page that just simply explains to them this is the methodology, what's going on here. Because a lot of these --

MR. STEIGER: The tables I referenced would be covered by a one-page narrative I'm assuming.

MR. HORWITZ: Just to have it.

MR. STEIGER: Including a title.

MR. HORWITZ: Is the Griffith paper there, the 50-page thing I referenced is what you're calling the Power Point, right?

MR. ASMUSSEN: No. No.

MR. STEIGER: Power Point presentation plus Griffith's paper. The Griffith paper was sent out as part of the last Bed Need Ad Hoc reading materials.

MR. HORWITZ: Do you think anybody on the Commission will ever read that?

MR. ASMUSSEN: No.

MR. HORWITZ: I'm just wondering do you want to send them the Griffith paper?

MR. ASMUSSEN: That's my point.

MR. STEIGER: If they don't read it, they're going to have a hard time making negative comments about it.

MS. MILLER: I think it's just- while we recognize, I would recognize the fact a lot of these folks won't read it,

we're just killing trees, but given the testimony and comments this morning about there are some people that want to know all the gory details, give it to them. The document has been in existence for a long time. Certainly it was the heart of what we did. We just tried to take that Power Point and boil it down into something that was more understandable.

MR. BALL: If you look at what the department has drafted for Section 3, it talks about the methodology described by the Griffith paper. And I think if I was on the Commission I would be saying, well, what is that? So, I'm going to either be giving it at the Commission meeting or I'm going to be giving it in the premeeting materials, and we only have to kill the trees once if we send it out to them in advance. We don't need to distribute it to them again at the meeting. So, I guess I would go with the overinclusive and send it out in the original package.

MR. FALAHEE: I guess the question for Stan, Stan, what was just passed out, I'm not an algorithm person either, do the changes here match what we've discussed all day? There's nothing new in here?

MR. NASH: This is Stan. The answer is Section 3 is a new revised methodology for determining the sub-area assignment for a new hospital. It is the methodology that the TAC committee used for the current sub-area assignment.

MR. HORWITZ: When we're done with what we're sending them, I have a question about the draft.

MR. FALAHEE: The reason I raised it is, Jim, to your point, and the question is how much do we give them on paper and how do we present it to them when they don't fortunately live, eat, and breathe methodology and algorithms? And I for one agree with Cheryl, and others, give them the data. It will cost you a tree or two, but it's there in case someone wants to say look what we went through. But, Jim, your point, how much detail do you have to get into? I wouldn't talk about the methodology much at all because it's going to go over most of their heads. And I think they need to realize, do I, not being a member of the TAC, rely on what the TAC did? It's two years of hard work. I rely on that.

MR. BALL: Let's recap what we have here. We were going to send -- the department is going to send the members of the commission the November presentation.

MR. STEIGER: Why don't you start with the summary.

MR. BALL: The executive summary.

MR. STEIGER: Which includes the one-page verbal summary, written summary, and then the sub-area, the new sub-areas and the new bed need numbers. That's going to be the essence of the executive summary.

MR. BALL: Then --

MR. STEIGER: Keep going.

MR. BALL: A copy of the --

MR. STEIGER: Power Point.

MR. BALL: -- Power Point presentation.

MR. STEIGER: Which probably to be complete, Cheryl, we probably would want to include the sub-area definition and the new bed need numbers.

MS. MILLER: There is some tweaking.

MR. BALL: Are you going to try to do that before they send this out or --

MS. MILLER: Yes.

MR. BALL: -- are you going to let them send it out and do that update at the December 9th --

MR. STEIGER: I think we can let them send it out. We can throw in the appendices. That's just putting them in as appendices. I don't know if we left enough blank.

MS. MILLER: If there's a handful of folks that can get together tomorrow at 8:00 or 8:30 and get something turned around and electronically sent to Larry by noon, that's the bottom line.

MR. STEIGER: That's the deal, so.

MS. MILLER: I mean, personally I would like to take the November 5th version, we know there's some basic changes that need to be made, and give him the cleanest copy possible.

MR. BALL: We send out the Power Point presentation of 11/5, updated if possible. And if it's not possible to do that so we can get it out, the importance is to get the stuff out to the commission members tomorrow. Then also attached would be the Griffith paper. Anything else?

MR. STEIGER: Plus I think it would be reasonable to send out, at least I'll throw this out on the table, the clarifications along with the letter that came from the Technical Advisory Committee. We discussed that this morning. I think that would be useful if anyone cares to --

MR. BALL: You mean the TAC response to the Sparrow, original Sparrow letter?

MR. STEIGER: Correct.

MR. O'DONOVAN: This is Patrick O'Donovan. Will the departments be sending out to the Commission the language in CON standards format like this that will also include an updated, the updated appendices based on these discussions so they'll have that as well, that's another piece that will go?

MS. ROGERS: That's why we brought that today in anticipation so the committee will have a chance to take a look at what the changes are going to have to be in the language. And if you okay that, then yes, we will be including that along with the updated appendices and everything else that's going to be updated in those standards.

MR. STEIGER: Which means so far we have the numbers and the sub-areas in three different spots, which seems to be a bit excessive.

MR. HORVATH: That's why when you said in the executive summary you want new numbers, if the committee adopts this today Brenda will be working to update the standards, which you can reference the methodology, which is now updated in the standards to the sub-areas. And the bed -- the bed numbers --

MS. ROGERS: Yes.

MR. HORVATH: -- will be updated in the standards.

MR. STEIGER: Larry, is that enough clarification for you? You had raised the point a minute ago about --

MR. HORWITZ: Yes. The only issue I had was about the standard. I think that is just fine.

MR. HORVATH: We will have a one-page executive summary that a couple members will try to work on tomorrow. We will have an updated Power Point presentation. If not, you guys will give us a call and we'll just go with the November 5th one. We will include the Griffith paper and then we'll include the TAC letter. Probably should include the Sparrow letter if they haven't received it to accompany it, and then the revised standards in this Subsection 3 and 4.

MR. STEIGER: I guess I'm still a little confused about the executive summary, because is there any way to work -- assuming this language gets approved, is there any way to work this into the executive summary?

MR. HORVATH: I'm not sure. I mean the executive summary I think was coming from Bob saying what you really need is something brief, concise, for the Commission.

MR. ASMUSSEN: Exactly.

MR. HORVATH: What is old, what is new today.

MR. ASMUSSEN: For example, we reduced the number of sub-areas by seven. There have been -- we violated the HSA designation three times for these three hospitals. Whatever the -- all the rest of the adjustments, because you can count on most of them just reading the executive summary and nothing more. You want to make sure they understand what is different tomorrow than the case today.

MR. BALL: The areas go down, the bed need goes up.

MR. ASMUSSEN: Right.

MR. BALL: Every area is still overbedded. Those key bullet points.

MR. VeCASEY: You could have two pages.

MR. ASMUSSEN: And what I would do on the second page or wherever the executive summary ends, show the appendices and title them and then to the extent they're interested, they can pour through it all, they can pick out appendix four, whatever it might be.

MR. STEIGER: Good point.

MR. BALL: Sounds like a plan. So, can we move on then to review what the department has provided here?

MR. HORWITZ: Jim.

MR. BALL: Larry.

MR. HORWITZ: I need to leave in a moment. I'll ask Barb to fill in for me. Let me just- there's a question of technical consistency. The folks don't have- it's on Page 3 of the standards if you have your standards. There is a term defined called relevance index which is called Percent Z. Then in this Section 3 we create a discharge relevance factor, which doesn't have any letter associated with it. Then in Section 4 we have something called the relevance index. I would think that you need to have different words and phrases for these things, different things.

MR. NASH: This is Stan. They're already in the definition section and they're worded exactly as they are in the definition section, Section 2 I believe.

MR. HORWITZ: The phrase says, relevance index, Percent Z. On this little thing you call it a discharge relevance factor. That's a different phrase. Is that intended to mean the same thing as Percent Z?

MR. NASH: In Section 2, and I quote, discharge relevance factor, and further on there is a relevance index, which is a V, and it says relevance index or market share factor and in parentheses it has Percent Z.

MR. HORWITZ: I understand. I'm looking at that. So what I'm saying we have two things, discharge relevance factor and we've got relevance index, right? Very similar sounding things, but they mean something different, right?

MR. FALAHEE: I think what Stan is saying is that they are defined differently in the definitional section. And that's why when they're talked about separately in here, it's okay because of the prior section's definitions.

MR. BALL: But is average discharge relevance factor R defined someplace?

MR. NASH: Yes.

MR. HORWITZ: Okay. On here it says, Section 3 giving us specifics on how we calculate percent R.

MR. NASH: No. This is Stan Nash. The way you calculate those two factors is contained within the definition for those two factors.

MR. HORWITZ: It says enumerator of the hospital discharges for HSA.

MR. HORWITZ: That' s means I' m being clear as to my intent. All I' m saying to the department, I just think maybe it can be dealt with after public comment if it goes that far. I think it' s just incredibly confusing to have in this piece of paper a thing that says a population weighted average discharge relevance factor. You' re telling me that' s
different than percent R?

MR. NASH: Correct.

MR. HORWITZ: I' m just saying that I think it' s confusing to use the same letter of the alphabet and very similarly the same words and telling me that it' s different. Here we' re calling it discharge relevance factor, Percent R, and average discharge relevance factor, are two different things. I assume they' re related to the other. Okay. That' s only my suggestion. I don' t understand that.

MR. NASH: This is Stan. Correct me if I' m wrong, it' s your suggestion that we come up with some kind of nomenclature that will --

MR. HORWITZ: Distinguish the difference between average R and percent R and don' t use the same letter of the alphabet.

MR. NASH: And Percent Z.

MR. HORWITZ: And Percent Z. You' re using very similar words and you' re telling me they mean different things and relevance factor and relevance index is involved in all of them.

MR. VeCASEY: These are defined differently in the other part.

MR. HORWITZ: I understand. But you have to be real adept to understand it. You called this other one -- Percent R is also called market share factor. Why don' t we use that term for the Percent Z so we don' t have three things that are using the market share average factor meaning three different things. I think it' s terribly confusing. I leave that for everyone to think about.

MR. HORVATH: We' ll take a look at it. This is no different than what has been included in the past. It is not something that people are going to take -- I don' t think the commissioners are going to calculate this out.I don' t believe they' re statisticians. It' s the same language that has always been there.

MR. STEIGER: There is one of the commissioners that may.

MR. HORVATH: It' s the same terms we have used in the past on this methodology.

MR. BALL: If the record could reflect that Barbara Jackson is replacing Larry Horwitz. Barbara Jackson is designated alternate.

MS. JACKSON: I' m not replacing him.

MR. BALL: Substituting.

MS. JACKSON: Thank you.

MR. BALL: We suggest that there be a round of applause.

MR. HORWITZ: Thank you, sir. (Mr. Horwitz left the room)

MR. O' DONOVAN: This is Patrick O' Donovan. I want to make sure I' m following the lettering and numbering correctly. On the second page of the handout near the, you know, near the top, Section 5, it says, if there is only a single applicant, the assignment procedure is complete. If there are additional applicants, steps three, four, and six must be repeated until all occupants have been assigned. This is Section 5 and I didn' t see a Section 6.

MS. ROGERS: There should be just Section 3 and 4.

MS. EBERS: This is Deb Ebers. On the first page there' s just a phrase that' s crossed out. Market forecast is crossed out and small number one, I, and then on the next sentence it refers to market forecast factor again instead of discharge relevance factor. It seems like we ought to be consistent, unless those are two different things, Stan.

MR. NASH: I would have to look at the definitions, but we tried to keep it as consistent as possible and we will check that to make sure that that occurred.

MR. HORVATH: We' ll double-check that.

MR. BALL: Is there any comments with regard to what the department has submitted? If there aren' t, I would entertain a motion to adopt this with the corrections that
have been suggested.

MR. ZWARENSTEYN: I' ll make the motion and also give the department a little leeway if in final proofreading they find another I that needs to be dotted, that they can go ahead and do that.

MS. EBERS: Supported.

MR. BALL: Supported by Deb Ebers. Any discussion? Seeing none, I' ll call for the question. All in favor, say aye. (Vote taken)

MR. BALL: Opposed? (None voiced)

MR. BALL: Motion is carried. I think that is the final item for today, other than public comment. Dale.

MR. STEIGER: I would just like to say before we break up that we' ve lost a lot of people from the audience, but the Technical Advisory Committee has put in a lot of work over the last couple of years, but I want to say publicly on the record we couldn' t have done it without Larry Horvath and Stan Nash. Stan, as we all know, has supplied technical expertise and computer expertise and history and everything else over the years. He is an invaluable resource for the department. And I think we all who participated in this know we couldn' t have done it without him.

And equally important, we couldn' t have done it without Larry' s help. Larry shepherded this process through the administration, has help herd it through administratively. I think we all owe a debt of gratitude to him and to Stan for helping move this process through and in a timely fashion.

MR. BALL: I would add my thanks to that. I have sent a couple of missives off at one point or another over to the department, by God, we need to move here, and I think we have had good cooperation.

MR. ZWARENSTEYN: Just a historical note, you referred to the Griffith paper. I should point out that the initial ABCM project was chartered by the Michigan Association of Area Wide Comprehensive Health Planning Agencies, a body I happen to have the privilege of presiding over. The whole process, participation process initially took quite a while to get to the point of the paper you saw, and it clearly is not easy to update it, and my credit goes to the TAC and to this body for patience and so on, and bringing about the spirit in which it all came about in the first place has continued to be maintained. I think that is something that Jim especially in conveying that to the CON Commission, I hope you' ll underscore the notion that everybody was invited and allowed fully to participate and does reflect a lot of people who have different views, sometimes conflicting, but still they all came together on something that is very positive for the State of Michigan.

MR. BALL: Thank you. Is there any other public --

MR. O' DONOVAN: Just to add onto Dale' s comments, you know, a lot of people who did a lot of work in the TAC that were identified, Stan and Larry. I think a couple of others deserve recognition. Certainly Bob Zorn provided a lot of assistance in terms of all the MIDB and all the analysis that went with it. Certainly, Bob Meeker was a very strong force in guiding us along, Cheryl Miller as well. I' d just like to recognize all these folks, not to the exclusion of anyone else, but just a lot of work done by those folks as well.

MR. BALL: Thank you. Are there any public comments that we haven't-

MR. VeCASEY: Did we include in our earlier motion the add-ons? By the way, these weren't in our charge, but these are suggested criteria for the comparative review?

MR. BALL: We had a motion that that would be done as a separate item.

MR. VeCASEY: I wanted to make sure.

MR. BALL: Okay. Seeing no public comment, I'll entertain a motion for adjournment.

MR. VeCASEY: So moved.

MR. ASMUSSEN: Supported.

MR. BALL: Supported by Asmussen. All in favor say aye. (Vote taken)

MR. BALL: Opposed? (None voiced)

MR. BALL: The meeting is adjourned.

(Meeting adjourned at 2:06 p.m.)

MINUTES APPROVED AND ACCEPTED BY:

Original signature on file — 1-23-04
James F. Ball, Chairperson — Date
Hospital Bed Ad Hoc Advisory Committee

Original signature on file — 1-20-04
Brenda Rogers — Date
Special Assistant to CON Commission